HUMAN RIGHTS

Report of an International Consultation on AIDS and Human Rights

Geneva, 26-28 July 1989

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The public health rationale for preventing AIDS-related discrimination

At the end of the 1980s—the first decade to know of AIDS—the world faces three interconnected epidemics—the epidemics of human immunodeficiency virus (HIV) infection, of HIV-linked disease, acquired immunodeficiency syndrome (AIDS), and of social, cultural and political reaction to HIV and AIDS. This third epidemic threatens increasingly to overshadow and overwhelm the epidemics of HIV and AIDS. Myths about HIV and AIDS persist, generally involving fears about casual contact. According to surveys throughout the world, from 10 per cent to 30 per cent of people still believe that HIV can spread through a handshake and that it is not safe to ride a bus or share a workplace with an infected person. Also, sadly, the twisted bring forth their twisted ideas, spreading their talk of "secret germ warfare", "massive cover-ups" and "AIDS conspiracies". This is harmful, for an African Minister of Health recently reported that such myths have reduced condom use because of the rumour that condoms have been contaminated with HIV. Finally, assaults on the rights and dignity of HIV-infected people continue to increase, involving work, education, housing and travel, even in countries which have thus far steadfastly resisted such discrimination.

Over two years ago, the foundation was laid for an international programme of concerted action and common purpose—the Global AIDS Strategy. The Global AIDS Strategy provides a practical framework for national efforts, literally around the world, and for international programmes. The World Health Organization Global Programme on AIDS is active in over 150 countries, providing financial and technical support for planning, training and implementing in the field. National AIDS programmes have been developed rapidly, with great energy and local creativity; such programmes now exist in most countries and should be established in all of the world's 187 countries and areas by the end of 1989 or early 1990.

As of 1 November 1990, 298,914 cases of AIDS have been reported to the WHO. However, because of extensive under-recognition, under-reporting and delays in reporting, WHO has estimated that by the end of 1990, over 800,000 AIDS cases in adults, and over 400,000 cases in infants and children will have occurred globally since the start of the pandemic, for a combined global total of over 1,200,000 cases. Furthermore, as of late 1990, about 8 million to 10 million people are estimated to be infected worldwide with HIV, of whom, about 3 million are women in the reproductive age group. The incidence of heterosexually transmitted HIV infection appears to be increasing rapidly, particularly in developing countries.

WHO has projected that by the year 2000, a cumulative total of 5 million to 6 million AIDS cases in adults may have occurred, and 15 million to 20 million adults cumulatively HIV-infected. Consequently, the number of infants born HIV-infected since the start of the pandemic may reach 10 million by the end of this century. The majority of these infants and children will either have progressed to and died of AIDS, or have died of another disease whose severity may have been accentuated because their immune systems were crippled by HIV infection. Thus, by the year 2000, AIDS and HIV infection in infants and children may lead to child mortality rates increasing as much as 50% over the present levels in regions where heterosexual transmission of HIV predominates. Moreover, by the year 2000, more than 10 million uninfected young children are likely to be threatened with orphanhood, as a result of the death of their mothers or both parents due to AIDS. This escalating burden of adults, infants, and children with AIDS and other HIV-related ill health will require continued and increasing solidarity from the entire international community.

Therefore, whether considering the cumulative number of AIDS cases worldwide, or the numbers of HIV-infected people, it is anticipated that the decade of the 1990s will be more serious, and perhaps much more serious, than that we have experienced during the 1980s.

To convert the initial effort of the 1980s into strong and resourceful programmes to deal with HIV infection and AIDS during the 1990s will, therefore, require sustained energy and commitment. Yet the epidemics of HIV and AIDS are but two of the three we will continue to face. The third epidemic of social, cultural and political reaction and response may be as important to our future as the virus itself.

In many countries, there is evidence that behavioural changes have occurred or are occurring which will help prevent HIV infection. After several years of experience in many countries, it is clear that, regardless of the cultural and social context, three elements have been present wherever positive behavioural changes have occurred. First, locally relevant and targeted information and education has been provided by credible sources. Secondly, the information and education has been linked with those health and social services needed in order to support and strengthen behaviour change. Finally, the entire programme has been imbued with the theme of support. A supportive social environment is a necessity, not a luxury. These are the principles which emerge from experience and they can be adapted to any setting or culture. Unfortunately, wherever information remains inadequate, inaccurate or frankly misleading, where needed health and social services do not yet exist, or where the entire effort is undermined by a discriminatory and punitive social environment—in these places, prevention has not yet been given a chance.

The World Health Organization has taken a series of strong and proactive stands to help protect the rights of, and prevent discrimination against, persons infected with human immunodeficiency virus (HIV). This position was reinforced by the 41st World Health Assembly, which adopted a resolution on 13 May 1988 entitled "AIDS: Avoidance of Discrimination in Relation to HIV-infected People and People with AIDS".

This resolution starts by urging WHO Member States to "foster a spirit of understanding and compassion for HIV-infected people and people with AIDS through information, education and social support programmes". Experience with national AIDS programmes has suggested that as public information and education increases in quantity and quality, irrational fears about HIV and its transmission tend to diminish. Nevertheless, while people may understand that HIV cannot be spread through casual contact, the specific and individual instance of an HIV-infected child in a school or an HIV-infected adult in the workplace can still provoke unwarranted but substantial anxiety and can unveil deep-seated prejudices. Consequently, the World Health Assembly resolution urges WHO's 167 Nation Member States "to protect the human rights and dignity of HIV-infected people and people with AIDS and of members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and travel". In addition, Member States are urged "to ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services to HIV-infected people and people with AIDS".

There is a strong and clear public health rationale for this emphasis on protecting the human rights and dignity of HIV-infected persons, including people with AIDS. HIV spreads almost entirely through identifiable behaviour and specific actions (sexual intercourse and intravenous drug use) which are generally—though not always—subject to individual control. In most instances, HIV transmission involves the behaviour of two persons; a change in behaviour of either the HIV-infected or the uninfected person will be sufficient to prevent HIV transmission. However, it must be remembered that HIV is transmitted mainly through behaviour which is private, secret, often hidden and, in some societies, illegal.

Therefore, if HIV infection, or suspicion of HIV infection, leads to stigmatization and discrimination (e.g. loss of education or employment), persons already HIV infected, and those who are concerned they may be infected, will actively avoid detection and contact with health and social services will be lost. Those needing information, education, counselling or other support services would be "driven underground". The person who fears he or she may be infected would be reluctant to seek assistance out of fear of being reported—with severe personal consequences. The net result would be to jeopardize seriously educational outreach and thereby exacerbate the difficulty of preventing HIV infection.

For these reasons, discrimination may endanger public health; stigmatization may itself represent a threat to public health. The World Health Assembly resolution, therefore, directs WHO "to stress to Member States, and to all others concerned, the dangers to the health of everyone of discriminatory action against and stigmatization of HIV-infected people and people with AIDS and members of population groups". Protecting the human rights and dignity of HIV-infected people, including people with AIDS, and members of population groups, is a necessity for effective public health programmes to prevent and control HIV/AIDS. It is not a question of the "rights of the many" or the "rights of the few"; the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of the infected person. Therefore, as the World Health Assembly has identified this issue as critical to the success of national and international AIDS prevention programmes, the protection of the rights and dignity of HIV-infected persons has become an integral part of the Global AIDS Strategy.

Around the world, there is evidence of growing complacency among some peoples and governments—and growing fatalism among others. Complacency invites marginalization—of groups or nations—and could tragically reduce the commitment of human and financial resources at this critical moment in national AIDS programme development. Fatalism can lead either to passive hopelessness or to proposals for simplistic and extreme solutions.

For this reason, solidarity is a transcendent and dominant need. In the 1980s, we have learned and we have taught that discrimination and stigmatization of HIV-infected people must be prevented—for the sake of all. More recently, we have discovered that beyond the limited concept of anti-discrimination there is a more positive and active quality—a respect for human rights and dignity—a spirit of active tolerance. Yet even beyond anti-discrimination and tolerance, there is a higher call—to solidarity.

Solidarity is at once a personal and a universal matter, for it raises the fundamental question of what is the "self" and what is the "other". One of the glories of our era is that we have witnessed the birth of global solidarity—imperfect, struggling, yet nevertheless real—in the creation of the United Nations, in the concern about nuclear war, in the growing worldwide resolve to protect the environment, and in AIDS.

We must practise the wisdom that refuses to separate the condition of the few from the fate of the many. We must prevent emotional negligence and indifference to the fate of peoples and nations. We shall continue to face painful and intractable aspects of life and society: complacency, ignorance, fear, discrimination, prejudice and hate; abandoned children; prostitution of boys and girls, men and women; drug injection; the suffering of those who are infected and ill and those who live with them; and death itself. Concerned with AIDS, we are drawn to solidarity. This

solidarity gives us confidence to continue to look into the face of AIDS—and know that we will not turn away.

As we mature as individuals, our innate feeling of personal immortality evolves into an awareness of our mortality, and this helps us in our search for understanding. And at some time we accept our common humanity, and this knowledge also helps us better to understand. Are we—is this world—now mature enough, now wise enough—to accept that the deepest meaning of solidarity requires that we consider ourselves as if we too were infected with HIV—that we are all—on a human level—seropositive?

WHO believes it will be essential for non-governmental and governmental human rights organizations to play an active and proactive role. Such organizations, particularly at the local and national levels, must help prevent discrimination against HIV-infected persons, persons with AIDS, or high risk population groups. An informed and alerted human rights network can help protect public health and promote the human rights and dignity of all persons, including those with HIV/AIDS.

The human rights network will continue to require clear, accurate and up-to-date information on HIV infection and AIDS. The World Health Organization, which has been given the mandate to direct and co-ordinate the global fight against AIDS, stands ready to continue providing the human rights network with useful and reliable information upon which all effective public health and human rights action related to AIDS must depend. At the national level, organizations concerned with human rights must:

- link with AIDS-related organizations, NGO and governmental organizations; and
- work with national AIDS Committees to help broaden understanding and seek effective alliances against AIDS-related discrimination.

The Global Programme on AIDS is committed to this task. We must break new ground and work together—to fight against AIDS—to protect human rights and dignity.

While many tragedies and struggles leave no visible trace once they are past we know that AIDS in the 1980s has altered us—in our world, in our countries, in our communities—and in our hearts. From our experience in the decade now passing, we know that we, and those who think and work and believe as we do, will not simply survive—we will prevail. For finally, it is the commitment and strength of individuals—hundreds and thousands of individuals—whose humanity and whose acts of solidarity illuminate the world—and our future.

The human rights rationale for preventing AIDS-related discrimination

AIDS is a global problem hence it demands a global response. This response has been provided by the global strategy for prevention and control of AIDS, adopted by the World Health Assembly and endorsed by the United Nations General Assembly. The Global AIDS Strategy has been universally accepted as the policy-framework for the worldwide effort to combat AIDS. This strategy includes promotion and protection of human rights, thus for the first time in history a strategy against a disease includes promotion and protection of human rights. Protection of human rights, especially protection against discrimination, has been stressed first by the World Health Assembly and then by the Commission on Human Rights and other global, regional and national human rights bodies as the core principle in the application of human rights to HIV/AIDS and all the other health issues.

AIDS is also a global challenge of unprecedented scope. In the field of human rights, it has threatened to undermine universal respect of human rights. Therefore, the Secretary-General of the United Nations, in his speech at the General Assembly on 20 October 1987, said that our fight against AIDS "is also a fight against fear, against prejudice and against irrational action born of ignorance. For these are the causes of some of the most critical violations of human rights".

The need for a co-ordinated response and concerted action by all parts of the United Nations has been postulated by the General Assembly in all its resolutions concerning AIDS. This Consultation has been a result of the co-operation of the Centre for Human Rights and the WHO Global Programme on AIDS. In 1988 the Centre started carrying out its co-ordinating role in addressing human rights aspects of HIV/AIDS. The Secretary-General requested the Centre to start collecting information on legislation and practices of countries, particularly on discrimination and the danger it entails. The Centre's role of acting as the secretariat to the human rights treaty bodies has included an increased attention to HIV/AIDS. A briefing on HIV/AIDS was held at the meeting of all the chairpersons of the human rights treaty bodies in October 1988. States' reports on the right to health, submitted under the International Covenant on Economic, Social and Cultural Rights, increasingly include descriptions of national AIDS policies, laws and practices. The Human Rights Committee has also included AIDS-related issues in the consideration of States' reports under the International Covenant on Civil and Political Rights.

The United Nations human rights bodies have introduced HIV/AIDS-related human rights on their agenda. In August 1988, the Under-Secretary-General for Human Rights, Mr. Jan Martenson, suggested to the members of the Sub-Commission on the Prevention of Discrimination and Protection of Minorities that they should address human rights problems raised by HIV/AIDS. The Sub-Commission considered AIDS and human rights in 1988, and asked Mr. Luis Varela Quiros, one of its members, to prepare a concise note on the methods whereby the Sub-Commission could study AIDS and human rights. In 1989, Mr. Varela Quiros was appointed the Special Rapporteur on this subject. In the same year, the Commission on Human Rights adopted resolution 1989/11 on non-discrimination in the field of health. This resolution reaffirms that non-discrimination should apply throughout the field of health to all people in all circumstances.

The importance of human rights stems from the fundamental principle that society in all its activities must respect the basic dignity of the human person. Moreover, stigmatization of and discrimination against people who are HIV positive and those with AIDS form an obstacle we have to combat first, to be able to combat the disease itself. The Secretary-General of the United Nations emphasized in his speech on World AIDS Day, 1 December 1988, "our determination [is] that the world should make war *against AIDS* and *not* against *people* with AIDS".

One might say that we have learned from past experience how not to react to disease but not how to act. Typical reactions were often fear and rejection rather than measures needed to contain and control diseases, not to mention the respect of human rights of those affected by the disease. It is sufficient to remind ourselves that not long ago the death penalty was applied against persons whose only "crime" was a fatal or contagious disease. Punishment was used as if disease were a crime. Segregation, expulsion or detention of the sick was also frequent. The institution of quarantine has survived for centuries, and is sometimes proposed without a public health justification, as now in the case of AIDS. Plague barriers were used between countries in the 18th century, preventing passage for all except those with a certificate of good health. Similar certificates have been introduced today in the case of AIDS. There have been proposals to use old leper colonies for the internment of HIV-infected persons and people with AIDS. Such reactions testify to the fact that some of the fear and rejection that we know from history has survived. Conventional views die hard, and it is still sometimes heard that AIDS is a self-inflicted disease hence those affected should be punished and isolated rather than helped and supported.

Responses to AIDS have shown us that racism and racial discrimination are still unfortunately a long way from being eradicated. Racist interpretations of the origins and transmission of AIDS, and discriminatory practices applied with the pretext of combating AIDS, have to be combated.

AIDS-related discrimination has not been confined to the grounds of race and provenance. Open discrimination against HIV-infected persons has been reported often. Discriminatory practices also target persons suspected of possible infection with HIV, and a wide circle of those subsumed under the notion of "high-risk groups". Rather than by their own behaviour, people have thereby been categorized according to the presumed risk that their belonging to, or identification with, a group entails. "High-risk groups" have been defined on the grounds of sexual preference, lifestyle, or racial or national origin. Such categorizations entail the narrowing of the range of rights the person belonging to them can exercise. Prostitutes or drug addicts, regularly exposed to rejection and stigmatization, are often being victimized by repression and exclusion under the pretext of combating AIDS. This is not only an attack on basic human dignity but also it undermines efforts to reach these people and solicit their co-operation in combating AIDS which is indispensable in the strategy to prevent and control AIDS.

Such limitations of human rights have sometimes been justified by the false dilemma between the "rights of the few" and the "rights of the many". It has long been recognized in human rights that trade-offs undermine their very basis. In fact, international human rights law sets very strict conditions for restrictions in the enjoyment of human rights. Thus one cannot respect some rights at the expense of others, nor can one respect the rights of some while denying that others have equal rights. To justify AIDS-related discrimination a conflict was claimed to exist between the rights of the "uninfected majority" and the rights of those infected with HIV or ill with AIDS. Consequently, the rights of persons infected with HIV and AIDS patients were restricted or denied altogether. This does not represent a conceptual conflict between rights of some and rights of others, but between the recognition of human rights of all human beings and their denial.

Virtually all human rights are touched upon in the responses to AIDS, and this raises complex problems. The scope of human rights which seems to have been jeopardized by various responses to AIDS is large indeed.

Most importantly, AIDS threatens human life. The right to life is the fundamental right and the obligation to protect it reaches far beyond prohibitions of intentional or arbitrary killings. The right to life entails the obligation of governments and of the international community to undertake all the appropriate measures, to the utmost of their resources, to protect human lives. Difficult choices have been imposed on policy-makers by the transmission of the HIV infection through activities which are illegal in many countries, such as intravenous drug use. The spread of infection through the sharing of needles by intravenous drug users prompted some governments to supply safe injecting equipment to protect lives which would have otherwise been jeopardized. Though the free supply of sterile needles has not made the abuse of drugs, or access to them, easier, such actions have been criticized because of their negative effects on the programmes to curb drug abuse.

The right to life and the principle of non-discrimination are cornerstones of international human rights law. Numerous restrictions on human rights and fundamental freedoms have already been enacted in a number of countries on the grounds of the protection of public health. The protection of public health is recognized to be among the legitimate grounds for the restriction of human rights. Limitations placed upon privacy, freedom of movement or individual liberty are sometimes dictated by the need to protect public health. The requirements which such restrictions have to satisfy are determined in international human rights law. WHO has declared on many occasions that such restrictions are not necessary in the case of HIV/AIDS, that there is no public health rationale for the imposition of quarantine, isolation or compulsory screening or testing. The human rights bodies are now faced with the task of examining the legitimacy of these restrictions and their compatibility with existing human rights standards.

The protection of privacy has been jeopardized by the introduction of compulsory screening and testing, and by the establishment of registers of HIV-infected persons. This has often led to restrictions of the right to work, to freedom of movement and residence, even to access to health care for HIV-infected people.

Moreover, HIV-infected persons have sometimes been deprived of their liberty. This may develop into indefinite detention, and even deprivation of their liberty for the rest of their lives. The United Nations human rights bodies have been dealing with legal safeguards against arbitrary and unlawful detention and these now need to be examined in the context of HIV/AIDS. If HIV-infected persons are placed in detention this may constitute administrative detention without charge or trial in violation of the existing human rights norms.

International migration and travel have been severely affected by responses to HIV/AIDS. These include restrictions on the freedom of movement, exclusion of HIV-infected persons from certain countries, or the use of compulsory tests to deport, exclude or detain HIV-positive persons, usually but not exclusively non-citizens. These measures raise a range of human rights issues, and necessitate tackling the complex area of the rights of aliens. Though these restrictions have often been invoked on public health grounds, WHO is consistently repeating that there is no public health rationale for them. No screening of international travellers can prevent the introduction or spread of HIV infection. Moreover, these measures may breach the non-discrimination principle and violate the rights of those targeted by them.

Children who got the infection from their mothers, most often before they were born, represent a challenge to our ability to respond to their needs while recognizing their rights. The number of children born infected with HIV is expected to increase to 10 million by the year 2000, but our response has not yet matched the challenge this perinatal transmission of HIV poses. Transmission of HIV from infected mothers to their children brought up dilemmas in a wide area of our work, from family planning to maternal and

child health care and to the recently adopted Convention on the Rights of the Child.

Combating AIDS is not confined to the circle of medical experts, scientists, government officials and health personnel. Everybody needs to be involved in the programme to prevent and control AIDS. The Global AIDS Strategy is based on the prevention of the further spread of HIV infection, using information and education as the main instruments to achieve changed and responsible behaviour. The challenge of AIDS has revealed the necessity of strengthening primary health care, and of setting up the basic infrastructure where it does not exist. An unprecedented international mobilization and co-operation in the past couple of years has demonstrated the ability of the international community to act. This assistance for the prevention and control of AIDS has reached an unprecedented level and is still increasing. It is carried out through technical assistance to all the developing countries which need and request it. As human rights have been included as a complement and reinforcement of public health principles, assistance provided within the Global AIDS Strategy has included promotion of human rights. Our Programme of Advisory Services and Technical Assistance in Human Rights has recently been further expanded to include the subject-matter of HIV/AIDS and human rights.

The importance of promoting human rights in the area of health cannot be over-emphasized. AIDS presents a challenge because responses to it have affected all human rights and fundamental freedoms; thereby it also represents an opportunity to reaffirm and reinforce human rights standards as they relate to HIV/AIDS and to the entire field of health.

International Consultation on AIDS and Human Rights

Final Document

1. Inter-disciplinary meeting

1. The United Nations Centre for Human Rights (the Centre), with the technical and financial support of the World Health Organization Global Programme on AIDS (WHO/GPA), convened a Consultation of experts at the United Nations Office at Geneva from 26 to 28 July 1989. The Centre's initiative was taken in the context of the World Public Information Campaign on Human Rights launched by the General Assembly of the United Nations on 10 December 1988. The WHO support was offered in the context of the global strategy for the prevention and control of AIDS and in accordance with World Health Assembly resolution WHA 41.24 on the avoidance of discrimination in relation to HIV-infected people and people with AIDS. The purpose of the Consultation was to bring together experts in the fields of law, religion, ethics, human rights, public policy and public health to discuss aspects of human rights, including various forms of discrimination in relation to the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

2. The inter-disciplinary meeting represented the first such coming together of the disciplines mentioned under the aegis of the Centre and with the support of WHO/GPA. Its primary objectives were to promote a better understanding of the human rights dimension of HIV/AIDS and to explore possible guidelines which might assist compliance with international human rights standards in decisions regarding law, administrative practice and policy. The Consultation also intended to give fresh emphasis to the importance of respect for human rights in the global struggle against AIDS. The participants welcomed the initiative to hold the Consultation. Several participants noted the need to strengthen the understanding of health issues amongst human rights specialists and of human rights among public health specialists. The initiative in convening the Consultation was especially welcomed because of the particular relevance of HIV and AIDS for human rights as reviewed and discussed during the Consultation. While the present Consultation was concerned principally with those rights protected by the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, it was recognized that there were many other aspects of human rights which were important for the

Global AIDS Strategy (for example, the rights protected under the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the relevant ILO conventions, and regional conventions on human rights). Some participants expressed the hope that the relevance of these rights to the Global AIDS Strategy would be emphasized in the appropriate context.

3. A list of the participants is contained in Annex I to this report.

2. The AIDS pandemic

4. The Consultation received expert advice from the Director of GPA, Dr. Jonathan Mann, concerning the present known status and projected future course of the AIDS pandemic in all parts of the world. It noted that the latest WHO figures at 1 July 1989 involved approximately 168,000 cases of AIDS reported from 149 countries. It noted that WHO estimated that this represented only a proportion of actual cases of AIDS and that between five million and ten million people were probably already infected with HIV. The available statistics indicate that HIV infection continues to spread rapidly. The World Health Organization, with constitutional responsibility to direct and co-ordinate international health work, developed the Global AIDS Strategy which has been universally adopted as the guide for global AIDS prevention and control. WHO's central role in the global effort against AIDS was formally recognized by the World Health Assembly (resolutions WHA 42.33, WHA 41.24 and WHA 40.26), ECOSOC (resolutions 1988/56 and 1987/75) and the General Assembly (resolutions 43/15 and 42/8).

5. The Deputy Director of the Centre, Mr. Kwadwo F. Nyamekye, in an opening statement, drew the attention of the participants to the two basic issues considered by the Centre to be vital to this problem:

(*a*) The issue of discrimination and the danger of the creation of new minorities and new structures of discrimination; and

(*b*) The rights of everyone to equitable access to health care and facilities.

He reviewed the efforts of WHO, other components of the United Nations system and the Centre, in identifying and dealing with the human rights aspects of this issue. He pointed to the interest of the Sub-Commission on Prevention of Discrimination and Protection of Minorities in the relationship between human rights and AIDS, and the co-operation between the Centre and WHO in that regard.

6. A background document, *AIDS and Human Rights*, was placed before the Consultation. It was introduced by the Chief of the External Relations Section of the Centre, Mr. John Pace.

7. Closing statements were made to the Consultation by Dr. Mann and by the United Nations Under-Secretary-General for Human Rights, Mr. Jan Martenson. Mr. Martenson underlined the complex nature of the problems involved and expressed the hope that the Consultation would facilitate the task of policy-makers as well as legislators. The Centre for Human Rights, in co-ordination with WHO/GPA, would be prepared to extend technical assistance and advice in the field of human rights. Mr. Martenson stressed the importance of strengthening national infrastructures for the promotion and protection of human rights and also of the need to enhance education and information. The World Public Information Campaign would be most useful in this regard and the proceedings of the Consultation would be published within this context.

3. HIV/AIDS AND HUMAN RIGHTS

8. The participants discussed the features of the social response to HIV/AIDS which present special risks of breach of human rights, particularly discrimination. They emphasized that a thorough understanding of the facts of HIV/AIDS was essential to sound ethical analysis and good public policy. Without exhausting all of the specially relevant features of HIV/AIDS, the participants noted in particular:

(*a*) There is no present cure for AIDS, and available palliative treatment is expensive and not readily available in all parts of the world;

(*b*) There is at present no vaccine against HIV;

(*c*) In many less economically developed countries, systems for screening blood and blood products are still non-existent or inadequate as a result of economic constraints;

(*d*) The consequences of infection by the virus are life-threatening;

(*e*) The virus has been identified relatively recently, and has quickly spread and is still spreading in many parts of the world;

(*f*) There are relevant limitations in the tests developed to determine whether a person who has been exposed to HIV has, in fact, been infected. In particular, the tests produce a proportion of false negative and false positive results;

(*g*) Because most of the tests so far used detect antibodies which develop after infection with the virus, there is a "window period" between the time of infection and the time of a positive test result which makes present HIV antibody tests an incomplete assurance that a person whose test result is negative is in fact free from infection with HIV;

(*h*) In some parts of the world, HIV has principally affected minorities who are already the subject of discrimination, stigmatization and legal sanctions. These include, in particular, persons engaged in prostitution, homosexual activity and intravenous drug use and heterosexual men and women infected with HIV. The fact that people in these groups have been particularly affected by HIV/AIDS has increased the special risks of their further marginalization and of deprivation of their basic human rights;

(*i*) As demonstrated by centuries of effort in all parts of the world, behaviour modification in drug-taking and sexual activity cannot be achieved solely through the use of law; and

(*j*) Persons infected with HIV typically do not become sick for years and even decades after exposure, during which time they may be able to continue to lead useful and full lives but may—unknowingly in most cases—infect others.

9. The participants noted that the most effective means currently available to prevent the spread of HIV was to promote positive behaviour among persons infected with HIV and those at risk of exposure to infection. In some societies, the behaviour which contributes to the spread of HIV is regarded as immoral or illegal. Yet success in stemming the further spread of HIV depends upon winning the confidence and co-operation of such persons in order to be able to provide them with information, education and support to promote changes in their behaviour. However, discrimination or stigmatization may discourage them from seeking relevant services. It was for this reason, amongst others, that the World Health Assembly stressed the need to assure respect for the human rights of HIV-infected persons and those with AIDS and also those at risk, or apparent risk, of exposure to HIV. There is, thus, a clear public health rationale for protecting people from discrimination. It was also for this reason that the Centre, within the context of the World Public Information Campaign for Human Rights, took the initiative of convening the Consultation.

10. The participants recognized the risk of the adoption of measures which are not based upon a sound understanding of the features of the virus and its modes of transmission based on both the understandable fear and concern which the epidemic causes to individuals, Governments and public health officials. Already some such measures have been adopted in several countries. In the opinion of the participants, the past history of oppressive and ineffective responses to infection and disease serves as a warning to the international community of the particular risks of discrimination and loss of human rights in the face of the HIV/AIDS pandemic.

11. The participants recalled the unprecedented efforts of the international community, particularly under the aegis of the United Nations, to produce a body of international human rights law expressing universal human rights standards. These standards are specifically relevant and applicable to persons with HIV/AIDS and also relate to the right of others to health,

including access to information necessary in order to avoid exposure to HIV and the risk of AIDS. Provisions in binding international human rights instruments and in declarations, resolutions of the General Assembl, and other sources were reviewed by the participants. In this review, the participants also had before them the background document (HR/AIDS/1989/1), and the study by the late Mr. Paul Sieghart "AIDS and Human Rights—A U.K. Perspective" (British Medical Association Foundation for AIDS; London, 1989).

12. The attention of the participants was drawn to applicable provisions of fundamental human rights. The participants recognized that the fundamental rights of one individual were sometimes affected by the assertion of the fundamental rights of another. The achievements of a proper reconciliation between their respective rights requires knowledge, judgement and a careful balancing of the applicable rights with special care to avoid the risk of discrimination or the unjustifiable loss of basic human rights by the one in the name of protecting the human rights of the other.

13. In the past, departures from respect of universal human rights have sometimes been justified by an appeal to the exception applicable in some cases for measures required to achieve a legitimate aim of society. In the context of HIV/AIDS, the protection of the rights and freedoms of others and the protection of public health are frequently mentioned. But the participants stressed that an exemption from observance of universal human rights could not be justified simply by claiming that a measure was required for "public health" reasons. The participants stressed that international human rights law was significantly more precise than this. It was also necessary, in each case, to establish that the exception was provided for with precision:

(*a*) By a *specific law* which is accessible and which contains foreseeable standards as opposed to administrative policy or individual discretion not based on legal rules;

(*b*) By such a law which in the circumstances could be shown to be *strictly required* to achieve a legitimate purpose of society for which a pressing social need could clearly be shown; and

(*c*) In measures *strictly proportional* to the achievement of the pressing objective so defined and to any harm inflicted, and which are the least intrusive and restrictive measures available.

14. Some participants expressed the view that a reconsideration of the "public health" exception in certain human rights instruments was required by a consideration of the particular dangers to human rights demonstrated by certain measures described as being for "public health" purposes. Other participants thought it sufficient to stress the fact that universal human rights continue to apply and that the exception for "public health" is strictly limited in the ways referred to above.

4. General observations

15. The participants then turned to a consideration of:

(*a*) The audience to which the special concerns about the respect for human rights in the context of HIV/AIDS needed to be particularly addressed;

(*b*) The particular concerns that should be addressed given the necessary constraints of their meeting; and

(*c*) The form in which future initiatives to protect human rights in the context of HIV/AIDS should be expressed.

16. The participants laid emphasis upon the need for education in international human rights standards at the following levels:

(*a*) The components of the United Nations system;

(*b*) Other international, regional and inter-governmental bodies;

(*c*) Member States to which the relevant international instruments were expressly addressed;

(*d*) Non-governmental organizations and community groups; and

(*e*) Individuals.

Although it was recognized that in many of the above there was a full appreciation of applicable human rights standards, and that important progress in this regard had been made, this has not always been the case. In the past, the content of such human rights standards may either not have been known or understood by public health officials or was regarded as not applicable due to the exigencies of public health. Likewise, the point was made that, in the past, legal advisers may not have always been aware of the needs of public health. The participants considered that it was important to bring home to officials in all relevant national and international agencies, concerned with developing and implementing HIV/AIDS policy, the importance and the relevance of international human rights standards to their tasks. In many cases, such standards have been specifically accepted by Member States and therefore must be complied with in the context of HIV/AIDS.

17. The participants also drew attention to the importance of translating human rights standards, in international instruments and elsewhere, to actual observance when they were most needed. In this context, they stressed the necessity of education in human rights, the work of non-governmental and governmental agencies, and the need to provide for the enforcement of human rights by international supervisory bodies or in independent courts or tribunals. In addition, anti-discrimination legislation could provide individual redress where this is justified and assist community education in replacing fear and ignorance with knowledge and enlightenment. The fulfilment of the right to health information and education about HIV/AIDS and the means of

preventing the spread of HIV was emphasized as an indispensable first step in self-protection and the protection of others.

18. As to the general concerns of the participants, the following in particular were noted:

(*a*) The participants observed that the Global AIDS Strategy developed by WHO and endorsed by the General Assembly of the United Nations had accepted, from the outset, the imperative necessity, in the realization of its objectives, for the respect of the human rights of all those concerned including the prevention of discrimination against HIV-infected persons, persons with AIDS or persons at risk, or thought to be at risk, of exposure to HIV. The participants endorsed the strategy of WHO/GPA in this regard. In their view, no other strategy would be consistent with observance of internationally accepted human rights standards. Moreover, no other strategy would, for the reasons already referred to, be likely to succeed in the prevention and control of HIV/AIDS;

(*b*) The participants believed that the United Nations World Campaign on Human Rights provided an important channel through which relevant information and education could be promoted. The work, which was initiated in the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, could provide a useful basis upon which applicable health and human rights priorities could be identified. In this regard, it was necessary that the Centre and WHO/GPA continue to work closely together;

(*c*) Although human rights are, by their nature, universal, the participants recognized that there was room for legitimate differences of view about the interpretation of some rights, their applicability in particular situations and the relevance to them of some cultural differences. Different views of the meaning of provisions of international standards which have not yet been interpreted by the relevant bodies are, in part, an inescapable aspect of the ambiguity of language which gives rise to opportunities for judgement and choice of meaning. Nevertheless, the global challenge of AIDS and its international character draws new attention to the universality of human rights standards and to the fact that they are inherent in people as human beings. Human rights must be respected as an attribute of the uniquely precious value of each human life and not just because they are laid down by law or because their observance promises greater success in combating AIDS;

(*d*) Although the human rights of all need to be observed and protected, the features of the AIDS pandemic and the urgent necessity of its containment call particular attention to the need for protection of the human rights of those especially at risk of exposure to HIV so that they will be empowered to protect themselves. By so doing, they are enabled to fulfil their responsibility to protect others. In different parts of the world this includes the special need to ensure the protection of the human rights of persons engaged in both female and male prostitution, male homosexual activity,

intravenous drug use, and the protection of heterosexual men and women infected with HIV;

(*e*) The participants considered that, in the context of HIV/AIDS, special attention should be given to the human rights of women. There are certain factors relating to the reproductive role of women and their subordinate position in society which render women particularly vulnerable to infection. The subordination of women may vary in degree in different societies, but its nature remains the same. Women typically lack equal access to education, health, training, indepe dent income, property and legal rights. This affects both their access to knowledge about AIDS and the measures that may be taken to prevent transmission of HIV infection, as well as their ability to protect themselves from infection.

19. There was considerable discussion amongst participants about the desirability, in the current circumstances of HIV/AIDS, of the elaboration, by the Commission on Human Rights, of a relevant international instrument specifically addressed to the human rights problems raised by HIV/AIDS, including the need for measures to prevent and redress discrimination. Upon this subject, the views of the participants differed. In summary, without exhausting the opinions expressed, those who opposed such an initiative expressed the views that:

(*a*) It would require the devotion of much time and resources in circumstances of urgency where there were already applicable provisions;

(*b*) It ran the risk of isolating HIV/AIDS from its proper conceptual setting as a matter of health care and social justice or as an illness or disability and of thereby promoting the further marginalization of persons with HIV/AIDS;

(*c*) It ran counter to the current tendency to resist the expansion of international human rights law, in order to allow concentration upon the implementation of the law already adopted, of which there was a great deal that was clearly applicable to HIV/AIDS; and that

(*d*) It ran the risk, by re-opening debates on the specific topic of HIV/AIDS in present circumstances, of undermining the welcome strategy of WHO concerning human rights and HIV/AIDS and providing an outlet for ill-informed fears and prejudice.

20. On the other hand those who favoured such a course referred to the following considerations, amongst others:

(*a*) The existence of particular and specific international human rights instruments addressed to particular and specific problems of which HIV/AIDS is undoubtedly as important and challenging as many;

(*b*) The evidence of the benefit to the advancement of respect for human rights in the existence of human rights laws, both national and international;

(*c*) The stimulus given to the enactment and effective implementation of national and local or provincial laws and the adoption of policies by the achievement of international instruments dealing with particular issues of importance for human rights;

(*d*) The focus which such an instrument would provide to individuals and advocacy groups working towards preventing or redressing discrimination;

(*e*) The opportunity which such an instrument would present to strengthen the protection of the human rights of persons suffering from all forms of ill-health or disability;

(*f*) The assistance given to the national and local or provincial political process in the protection of the human rights of unpopular or stigmatized minorities by the existence of an instrument representing the consensus of the international community; and

(*g*) The probability that the challenges to human rights in the context of HIV/AIDS would become more pressing and serious with the global spread of the epidemic.

21. The participants invited international, intergovernmental and regional bodies concerned as well as national governments, in the light of these considerations, to consider whether there was need for new human rights instruments concerning HIV/AIDS at the international and national levels.

5. Specific observations

22. The participants noted that the fundamental basis of human rights law and standards is the recognition of the equal worth and dignity of every man, woman and child and that this is reflected in the principle of non-discrimination. As the Secretary-General of the United Nations has stressed, the common fight of humanity is against HIV/AIDS, not against those persons with HIV/AIDS.

23. In the context of HIV/AIDS, the participants stressed the particular importance of the obligation to respect the rights to information and education, and the right to the highest attainable standards of physical and mental health, as well as the need to prevent discrimination at the local, national and international levels.

24. The rights to information and education require that every individual should have access to accurate and up-to-date information about HIV/AIDS, the means by which HIV is spread and how best they might protect themselves and others from infection. The contents of such educational material and the means by which it is disseminated will necessarily vary in different cultural environments.

25. It was further recognized that particular attention needs to be given to ensuring that such information reaches the most disadvantaged sectors of society such as those who are illiterate. In addition, it was noted that experience already gained in educational projects aimed at combating the spread of HIV has indicated that the most successful projects are those in which the inherent dignity of the members of the target group has been recognized. Projects were more likely to be effective where members of the population concerned were actively encouraged and empowered to design and implement their own educational projects.

26. The right of everyone to the enjoyment of the highest attainable standards of physical and mental health requires, amongst other things, that persons should be entitled to equal access to those health care and welfare services which are available.

27. Another factor to be recognized is that the right to health care, including measures to prevent the spread of HIV, is restricted in some States by lack of resources on the part of the individual, community or State. The full realization of the highest attainable state of health, as well as the limitation of the spread of HIV, requires assistance to individuals, and the support of the world community to less economically developed countries.

28. Whilst recognizing the efforts being made by Governments and international bodies to prevent and control the spread of HIV, the participants noted that some of the policies proposed or implemented on the grounds of protecting public health raised very serious ethical and human rights issues. The participants were not able to consider all of the relevant issues. However, they noted, for example, the inequality of resources available in the fight against the spread of HIV, the need for a more equitable distribution of presently available drugs; the need for compliance with strict ethical and human rights principles with respect to vaccine and drug testing and the future need for an equitable distribution of effective drugs and vaccine which might be discovered. This Consultation specifically examined existing human rights standards relating to a number of areas of particular concern. A list of issues raised for further study by human rights specialists is found in Annex II. The often-controversial issues, and others not mentioned in Annex II, need further detailed and wide consultation and will form the basis of ongoing work on HIV/AIDS and human rights.

6. HIV/AIDS: Harmonizing public health and human rights

29. The participants expressed their appreciation of the initiative of the Centre and WHO in promoting the Consultation on the interrelationship of AIDS and international human rights standards. They expressed the hope that this Consultation and its outcome would result in other such joint initiatives concerning the interaction of human rights, law, ethics, health law and policy in connection with HIV/AIDS and also with other health issues. In all areas

of health the observance of human rights is essential. But in the context of HIV/AIDS, as the Consultation demonstrated, there are particularly urgent concerns. The most urgent of these is to remind those formulating relevant policies of the existence and terms of the applicable international human rights standards.

30. The participants strongly endorsed continued close co-operation between the Centre and WHO/GPA to harness the potential of both bodies in developing practical programmes aimed at furthering the results of this Consultation.

31. Observance of international human rights standards in the context of HIV/AIDS is not only legally required, but pragmatically useful to the prevention and control of AIDS and a moral imperative of humanity.

32. The participants emphasized that it is important to recognize expressly their consensus and not just differences in relation to issues raised by HIV/AIDS. All of humanity can unite in endeavours to combat the spread of HIV and to support persons with AIDS. All share the common objective to prevent the further transmission of HIV.

Recommendations

1. The participants recommended that the Centre for Human Rights and WHO/GPA transmit this statement to the following bodies with a request to place this item on their agenda and to consider what action should be taken to protect the human rights of persons at risk or affected by HIV/AIDS:

(*a*) Each of the four human rights treaty bodies (the Human Rights Committee, Committee on Economic, Social and Cultural Rights, Committee on the Elimination of Racial Riscrimination, and Committee on the Elimination of Discrimination against Women);

(*b*) Each regional human rights treaty body (the European Commission on Human Rights, Inter-American Commission on Human Rights, and the African Commission on Human and Peoples' Rights).

2. The participants recommended that Governments ensure that measures relating to HIV/AIDS and concerning persons already infected conform to international human rights standards, and that they re-examine the measures already in force for the protection of human rights in the light of the particular issues raised by HIV/AIDS.

3. The participants recommended to WHO/GPA, in collaboration with the Centre for Human Rights, that it prepare and distribute practical information to national AIDS programmes on the international human rights instruments which are relevant to measures relating to HIV/AIDS and on the importance of the need to comply with these instruments.

4. The participants recommended to the Centre for Human Rights that, in collaboration with WHO/GPA, it prepare and distribute relevant information to international, regional and national human rights organizations on AIDS, the Global AIDS Strategy, and on the need to ensure vigilantly that measures relating to HIV/AIDS are in conformity with human rights standards.

ANNEXES

ANNEX I

List of participants and observers

PARTICIPANTS

ANDO, Nisuki	Professor of International Law, Member of Human Rights Committee
BAYER, Ronald	Associate Professor of Public Health, Columbia University, New York
BURDEKIN, Brian	Commissioner Australian Human Rights and Equal Opportunity Commission, Sydney
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DAWSON, John	Undersecretary, British Medical Association, Director, British Medical Association Foundation for AIDS, London
DELANEY, Sister Joan	Consultant, World Council of Churches, Geneva
DICK, Bruce	Health Department, League of Red Cross and Red Crescent Societies, Geneva
DILLOWAY, James A.	International Humanist and Ethical Union, Geneva
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DORKENOO, Bernard D.	Director, Human Rights Media Service (HURMES), Geneva
DUALEH, Mohamed	Public Health Officer, Office of the United Nations High Commissioner for Refugees, Geneva
EVATT, Elizabeth	Chairperson, Committee on the Elimination of Discrimination against Women, Vienna
FLUSS, Sev	Chief of Health Legislation, World Health Organization, Geneva
FUENZALIDA, Hernán	General Counsel Pan-American Health Organization, Washington
GEDDES, David	Secretary-General, Law Association for Asia and the Pacific (LAWASIA), Australia

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KELMAN, Rabbi Wolfe	Chairman, American Section World Jewish Congress, New York
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KUMAR, Jay	International Commission of Health Professionals, Geneva
LACK, Daniel	World Jewish Congress, Geneva
LAURIN, Yves	Legal Advisor, International Federation of Human Rights, Paris
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NOWAK, Manfred	Director, Netherlands Institute of Human Rights, Utrecht
NUSSBAUMER, Marianne	Representative, Pax Christi International, Geneva
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PERRET-NGUYEN, H. T.	Chief, Equality of Rights Branch, International Labour Organisation, Geneva
PERRIN, Pierre	Medical Division, International Committee of the Red Cross, Geneva
SHORT, Roger	Professor of Reproductive Biology, World Health Organization, Geneva
SOMERS, Lucas	Jurist, International Labour Office, Geneva
SOMERVILLE, Margaret A.	Director, McGill Centre for Medicine, Ethics and Law, McGill University, Montreal
TARDU, Maxime	International Centre for Penal Studies, Messina
THOMPSON, Cecilia	Assistant to the Secretary-General, International Commission of Jurists, Geneva

VARELA QUIROS, Luis	Member of the Sub-Commission
WAKO, Amos	Special Rapporteur on Summary and Arbitrary Executions, Member of Human Rights Committee
WIDDOWS, Kelvin	Jurist, Office of the Legal Advisor, International Labour Office, Geneva
WISEBERG, Laurie	Executive Director, Human Rights Internet, Harvard Law School

OBSERVERS

CURTIS, David	Third Secretary, Permanent Mission of United Kingdom of Great Britain and Northern Ireland, Geneva
MANN, Sue	Third Secretary, Permanent Mission of the United Kingdom of Great Britain and Northern Ireland, Geneva
ROSCAM ABBING, Henriette	Professor of Health Law, Legal Advisor, Ministry of Welfare, Health and Culture, The Hague
SEGURA, Jorge Rhenán	Deputy Representative, Committee on Racial Discrimination, Permanent Mission of Costa Rica, Geneva

ANNEX II

HIV/AIDS and human rights: Points for consideration

The participants considered the breadth of the ethical and human rights issues raised by HIV/AIDS, and of the international human rights instruments and standards relevant to this subject. They considered, for example, the relevance of the International Covenant on Economic, Social and Cultural Rights as well as the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination and the Convention on the Elimination of All Forms of Discrimination against Women, and other relevant instruments, including the numerous conventions and recommendations adopted under the auspices of the International Labour Organisation.

The participants were assisted by a background paper which outlined some, but by no means all, of the human rights issues raised by HIV/AIDS.

I

1. AIDS represents an urgent worldwide problem with broad social, cultural, economic, political, ethical and legal dimensions.

2. The Global AIDS Strategy developed by WHO and endorsed by the United Nations General Assembly has three objectives:

(*a*) to prevent HIV infection;

(*b*) to reduce the personal and social impact of HIV infection;

(*c*) to unify national and international efforts against AIDS.

3. In the realization of these three objectives, human rights must be respected and discrimination must be prevented.

4. International human rights instruments, including regional arrangements and treaties, and the decisions of courts and bodies established thereunder, provide a framework within which measures to limit the spread of HIV should be formulated.

II

The following measures are among those which appear consistent with international human rights standards:

A. With respect to the right to marry and to found a family, the provision of pre- and post-marriage information on HIV/AIDS and counselling of a non-directive, non-coercive nature, and the offer of voluntary HIV tests to marriage candidates, seem to comply with international human rights standards.

B. Measures based on the explicit, free and informed consent of the persons concerned seem to comply with international human rights standards; for example:

(*a*) the voluntary testing of individuals for HIV infection, anonymously or otherwise, with stringent safeguards for confidentiality;

(*b*) the counselling of individuals, both before and after they are tested;

(*c*) voluntary treatment to mitigate the effects of HIV infection;

(*d*) voluntary modifications of the behaviour of HIV-infected individuals, designed to prevent the transmission of the virus.

III

The following measures should be reviewed in the light of relevant international human rights standards:

(*a*) the mandatory testing of any individuals (other than voluntary donors of blood, semen, or other tissues or organs) for HIV infection, however selected;

(*b*) the compulsory registration of HIV-infected persons;

(*c*) the mandatory collection, storage and processing by a public authority of identifiable personal information about HIV-infected persons or those with AIDS without protecting the information concerned by the strictest rules of medical confidentiality or by anonymity;

(*d*) the disclosure of the results of HIV tests to third persons (including health professionals without the patient's consent) or permitting the improper discovery of such results by third persons (see below, point K);

(*e*) enforced admission to a hospital or hospice of such persons (see below, point J);

(*f*) compulsory isolation, quarantine or internment in a colony of such persons removed from the rest of society (see below, point J).

IV

A. Discrimination on the grounds of HIV/AIDS in areas such as access to education, employment, housing, has to be examined from the viewpoint of applicable international human rights standards.

B. The right to marry and found a family may be affected by:

(*a*) compulsory HIV tests for persons who wish to marry;

(*b*) mandatory abortions for or sterilizations of HIV-infected women;

C. HIV/AIDS also affects the rights of children. Particular issues which need to be examined include, *inter alia*:

(*a*) the rights of children to information and education to enable them to protect themselves and others against HIV infection;

(*b*) the difficulties of providing care and support for HIV-infected children or children from HIV-infected families, especially those who lose one or both parents.

D. HIV/AIDS also raises special concerns about human rights of women. These include, *inter alia*:

(*a*) vulnerability of women to HIV infection because of their disadvantaged position in the family and society;

(*b*) issues related to pregnancy in the context of HIV/AIDS;

(*c*) feminization of poverty and its relationship to prostitution.

E. The right of HIV-infected people and those with AIDS to public social security, social and medical assistance, or social welfare services needs to be analysed from the viewpoint of applicable international human rights standards.

F. The right to freedom of movement has been affected:

(*a*) when the entry into a country of its own nationals is conditional on their taking an HIV test, or obtaining a negative result;

(*b*) when the entry of aliens who would be otherwise admissible has been restricted on the grounds of HIV/AIDS status;

(*c*) when the entry of aliens has been restricted on HIV/AIDS grounds, this interferes with their enjoyment of other rights guaranteed to them by the applicable international human rights standards;

(*d*) by cases of expulsion on the grounds of HIV/AIDS status only;

(*e*) by cases of restrictions of liberty of movement within the territory of a State or the freedom to choose a residence for nationals or for aliens lawfully within that territory.

G. The denial of admission, attendance or exclusion from school of someone solely on the ground that he or she is HIV infected needs to be examined from the viewpoint of international human rights standards relating to education.

H. The denial of work, or refusal of employment or dismissal of an employee solely on the ground that he or she is—or is suspected of being—HIV infected needs to be examined from the viewpoint of international human rights standards relating to work and of the public health rationale for any restrictions considered. Compulsory or routine pre-employment or post-employment HIV testing need particular attention.

I. The right to privacy of the individuals needs to be examined in the following circumstances:

(*a*) when the prevalence of HIV in the existing population is estimated by unlinked anonymous screening. This is an epidemiological technique whereby samples of blood specimen that have been taken from individuals for other legitimate purposes is made completely anonymous ("unlinked") so as to make it impossible to relate the sample back to the individual from whom it was taken;

(*b*) when AIDS or HIV infection is made a notifiable disease by law, provided that the information reported is either wholly anonymous in the first place, or is protected by the strictest compliance with rules of medical confidentiality—that is, that it would only be released either anonymously, or with the express and informed consent of the person to whom it relates.

J. The following measures need to be examined from the human rights and public health viewpoint:

(*a*) the detention in an emergency of an individual known to be HIV infected who is unable to take care of himself of herself and who thereby presents an acute risk of infection to others;

(*b*) the detention of an individual while he or she is deliberately trying to infect others with HIV, provided that the person thus detained has the right to have the lawfulness of his or her detention established initially, and thereafter periodically, by an independent judicial tribunal.

K. The following measures which sometimes appear necessary to protect the rights of others may be considered provided that the person concerned is counselled, refuses to co-operate, and all persuasion failing, that the least restrictive measure is applied and, where relevant, a procedure for its revocation established. These measures include, for example:

(*a*) in the case of a high degree of risk of the transmission of HIV, informing the person at risk of the patient's known HIV status, provided that the circumstances in which this is allowed are either clearly defined by law or can be legally justified;

(*b*) the application of restrictive measures against an HIV-infected person who refuses to take preventive measures so as not to spread the infection.

ANNEX III

International Consultation on AIDS and Human Rights (Geneva, 26-28 July 1989)

Background Document

1. INTRODUCTION

1.1. The World Health Organization, which has as its primary function under Article 2 (*a*) of its Constitution to act as the directing and co-ordinating authority on international health work, has a particular concern, in the interests of public health, that AIDS and HIV infection should be approached from a social as well as a medical point of view. The protection of the rights and dignity of HIV-infected persons and persons with AIDS is an integral part of the WHO Global AIDS Strategy.

1.2. WHO is therefore seeking a consensus to affirm that this protection is offered by the existing international human rights instruments, which should consequently govern the public health policies and practices which governments might wish to adopt in order to limit the spread of HIV infection and AIDS within their populations.

1.3. AIDS is essentially a matter falling within the specialized expertise of medical science and public health and therefore within the direct remit of WHO. The promotion of human rights is one of the main purposes of the United Nations under its Charter and hence directly concerns WHO as a specialized agency (Articles 56 and 57). The human rights provisions of the Charter of the United Nations are elaborated in the International Bill of Human Rights as well as in over fifty other instruments. These are interpreted and supervised by the United Nations as well as other responsible bodies. It is the purpose of this document to outline and propose a resolution to some of the important human rights questions.

2. DEFINITIONS

2.1. The term human immunodeficiency virus (HIV) is used for the virus that causes AIDS (acquired immunodeficiency syndrome). HIV has replaced earlier names for the virus (HTLV-III, LAV) and in this document includes all related viruses (HIV-I and HIV-II). The term AIDS refers either to the specific clinical entity, the acquired immunodeficiency syndrome, or to the entire spectrum of pathological manifestations associated with HIV infection, and is so used in this document.

2.2. HIV-infected persons include all individuals, regardless of their clinical status, who are infected with HIV, as shown by confirmed positive serological tests.

3. HIV/AIDS

3.1. The epidemic of AIDS is a global health problem of extraordinary scale and extreme urgency. It represents an unprecedented challenge to the public health services of virtually every country in the world.

3.2. AIDS is caused by a newly recognized retrovirus called human immunodeficiency virus (HIV). One of the primary targets of HIV are T4 helper cells, a subpopulation of lymphocytes that are essential to the body's defence against disease. HIV infects and kills T4 helper cells, thus disrupting communication within the cellular and humoral immune system and progressively disabling the body's defence against disease.

3.3. At the present stage of the HIV pandemic, asymptomatic infection with HIV is far more common than AIDS. But HIV infection can progress and result in a wide range of adverse clinical manifestations. Clinical classification of disease associated with HIV infection includes AIDS-related complex (ARC), full-blown AIDS, including HIV-neurological disease.

3.4. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, and urine and is likely to be present in other body fluids, secretions, and excretions. However, despite this wide distribution, extensive laboratory and epidemiological studies indicate that only blood, semen, and vaginal/cervical secretions are important in the transmission of HIV. These studies have repeatedly documented only three routes of HIV transmission: sexual, by heterosexual or homosexual intercourse; parenteral, by blood or blood products (including transfusion of unscreened blood and the use of inadequately sterilized syringes and needles); and perinatal, from an infected mother to her foetus or infant. There is no evidence to suggest that HIV can be transmitted by other routes, such as respiratory or enteric routes, or by casual person-to-person contact in any setting, including household, social, work, school or prison environments. There is very small risk of transmission possible through participation in sports, especially combative sports with direct body contact and other sports where bleeding may be expected to occur. There is no evidence that HIV transmission involves insects, food, water, toilets, swimming pools, sweat, tears, shared eating and drinking utensils or other items such as secondhand clothing or telephones. After infection, most persons develop detectable antibodies against HIV within the first three months.

3.5. The incubation period between infection and the development of AIDS is long (an average of 8 years). Because HIV infection is presumably lifelong, the risk of illness may continue throughout the infected person's life. While infected persons may be asymptomatic for long periods, they are nevertheless capable of transmitting HIV. Infected persons are likely to be highly infectious to others at the earliest moments of infection, before the immune system has been fully activated and particularly before antibodies are detected, as well as during the symptomatic period. Owing to the long incubation period, the number of reported AIDS cases provides at best an inaccurate and at worst a misleadingly optimistic view of the real extent and intensity of HIV infection. Therefore, even if transmission were to cease immediately, clinical cases of AIDS would constitute a major and increasing public health problem for years to come.

3.6. WHO estimates that between 5 million to 10 million persons are currently infected with HIV. The cumulative number of AIDS cases globally may exceed one million by 1991. At present these cases cannot be prevented from occurring because most will occur among persons already infected with HIV. In addition, reticence in reporting cases from some areas as well as under-recognition and under-reporting to national authorities have meant that the number of reported AIDS cases represents only a fraction of the total number of cases. WHO considers the number of countries officially reporting cases (151 as of August 1989) to be more indicative of the geographical extent of the HIV pandemic than the number of reported cases, and more relevant to an assessment of its scope.

3.7. Although the modes of HIV transmission are constant, four broad yet distinct global epidemiologic patterns of HIV infection can be recognized.

3.8. In the first pattern (I), most cases occur among homosexual or bisexual males and urban intravenous drug users. Heterosexual transmission is responsible for only a small percentage of cases, but it is increasing. Transmission due to blood and blood products occurred between the late 1970s and early 1980s, but has now been largely controlled, at least in developed countries, through the self-referral of persons with known risk factors or behaviour and by routine blood screening for HIV antibodies; inadequately sterilized injection equipment, other than that used by intravenous drug users, is not a significant factor in HIV transmission. The male/female sex ratio ranges from 10:1 to 15:1. Mother-to-infant transmission does occur but the number of HIV-infected infants is low owing to the relatively low number of women currently infected. The overall prevalence of HIV infection in the general population is estimated to be less than 1% but it has been reported to exceed 50% among persons who practise high-risk behaviour, such as men with multiple male sex partners and intravenous drug users. This first pattern is typical for industrialized countries with a large number of reported AIDS cases, including North America, most western European countries, Australia and New Zealand.

3.9. In the second pattern (II), most cases occur among heterosexuals. The male/female ratio is approximately 1:1, and as a result mother-to-infant transmission is common. Intravenous drug use and homosexual transmission are either nonexistent or occur at a very low level. Because of the high number of HIV-infected women, perinatal transmission is common. In a number of countries it is estimated that the prevalence of HIV infection in the overall population is more than 1%, and that in some urban areas up to 25% of certain segments of the young and middle-aged adult population (15-49 years of age) are infected. Transmission through contaminated blood remains a significant problem in countries that have not yet implemented nationwide blood donor screening. In addition, the use of inadequately sterilized needles and syringes, or any other skin-piercing instruments, is considered an important public health problem. This second pattern is currently observed in sub-Saharan Africa and parts of the Caribbean.

3.10. In the third pattern (I/II), extensive spread of HIV commenced around the late 1970s or early 1980s. Initially, the burden of HIV infection was more or less confined to homosexual men with multiple sexual partners, self-injecting drug users sharing injection equipment, as well as recipients of HIV-contaminated blood or blood products. In the middle to late 1980s, increasing transmission among heterosexuals with multiple sex partners has been noted to the extent that the latter mode of HIV transmission has increasingly become, in pattern I/II areas, the predominant mode of HIV transmission. As a result, the male/female ratio of recent HIV infection has been found in some pattern I/II areas to be close to equal. As more heterosexual transmission occurs, an increasing number of paediatric AIDS cases resulting from transmission from an infected mother to her foetus or infant can be expected in these areas.

3.11. Those areas where HIV has only been introduced in the early to mid-1980s form the fourth pattern (III). Only a small number of AIDS cases have so far been reported from these areas (Eastern Europe, the Far East, the Near and Middle East, North Africa, Southeast Asia, and most of the Pacific). Cases have been recorded among homosexuals/bisexuals and self-injecting drug users; heterosexual transmission and transmission through blood transfusion or blood products have also occurred. Cases have mostly occurred in persons who have travelled to higher prevalence areas or those who could have acquired the infection from such persons.

3.12. Testing for HIV infection is carried out through HIV antibody assays. The techniques used, when performed by experienced technicians, are very accurate in detecting antibodies either to the whole virus or to its subcomponents. However, the ideal of 100% sensitivity (all true positives correctly identified) and 100% specificity (all true negatives correctly identified) will not be achieved in practice.

3.13. Depending on the sensitivity and specificity of the particular test used, HIV tests may thus sometimes produce a "false positive" result—that is, appear to show that a patient is HIV positive when he or she has not in fact been infected by the virus; or they may produce a "false negative" result—that is, appear to show that a patient is HIV negative when he or she has in fact been infected by the virus *and* has already started to develop antibodies. The earliest tests produced a high proportion of false positives and also some false negatives, because they could not detect the early production of antibodies. The best tests currently in use give accurate results in over 99% of cases if performed by experienced technicians.

3.14. In developed countries the cost of HIV tests is significant but not prohibitive. But in a country lacking resources, it may be so high that testing many people could absorb a substantial part of the resources available for health services, and in extreme cases distort the health budget, which may result in an increase in the number of premature deaths from other causes. However, the cost of tests has decreased substantially during the past years and may become even lower.

4. WHO—The Global AIDS Strategy

4.1. In late 1985, as the global scope and impact of HIV infection and AIDS was just being discovered, WHO initiated the development of the global strategy for the prevention and control of AIDS. This strategy was reviewed, revised and discussed widely in 1986 and served as the basis for initial WHO action against AIDS. The Global AIDS Strategy was then unanimously approved and adopted as the foundation for global action by the World Health Assembly (Geneva, May 1987), the Venice Summit of the Heads of State or Government (Venice, June 1987), the Economic and Social Council of the United Nations (Geneva, June/July 1987), the United Nations General Assembly (New York, October 1987) and the World Summit of Ministers of Health on Programmes for AIDS Prevention (London, January 1988). Thus the Global AIDS Strategy has been supported by every nation, the human and financial resources required to begin implementing this strategy have been mobilized, and the result has replaced the chaotic anxiety of the early 1980s with the structured, purposeful and increasingly powerful work of national and international AIDS prevention and control.

4.2. The Global AIDS Strategy establishes basic principles for national and international AIDS prevention and control, based firmly upon knowledge of HIV virology and epidemiology, and is derived from broad and practical experience with programmes to control infectious diseases. Therefore the Global AIDS Strategy provides the necessary framework, within which each country can develop its own detailed programme.

4.3. The Global AIDS Strategy has three objectives:

(*a*) To prevent HIV infection;

(*b*) To reduce the personal and social impact of HIV infection;

(*c*) To unify national and international efforts against AIDS.

4.4. The first objective is straightforward and clear: as drugs to cure HIV infection are not available, as infection with HIV is likely to be lifelong, and given its extremely serious personal and social consequences, it is essential to prevent new HIV infections. The second objective involves support and care for those who are already HIV-infected, regardless of whether they are presently healthy or have developed illnesses associated with HIV infection, including AIDS. The support and care of HIV-infected persons is not only humane, it is vital for the success of prevention and control programmes. The third objective arises directly from

the special and global nature of this problem and reflects the realities of the modern world, in which AIDS cannot be controlled in *any* country unless it is controlled in *every* country.

4.5. In the realization of each of these three objectives, human rights must be respected and discrimination must be prevented. There is no public health rationale to justify isolation, quarantine or other discriminatory measures based solely on a person's infection status. Therefore discrimination against HIV-infected persons threatens not only human rights, but effective prevention of the spread of HIV. We have seen all over the world that as people are informed about AIDS, panic and groundless fears recede. As leaders speak knowledgeably and clearly about AIDS, public confidence and commitment increase and illusory and simplistic solutions to the problems of AIDS are rejected.

5. THE PUBLIC HEALTH RATIONALE

5.1. In resolution WHA 41.24, adopted on 13 May 1988, the Forty-first World Health Assembly requested the Director-General to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups. The resolution stressed to the Member States and all others concerned the danger to the health of all of discriminatory action against and stigmatization of HIV-infected people and people with AIDS as well as members of population groups. A similar statement is included in the London Declaration on AIDS prevention.

5.2. There is a strong and clear public health rationale for this emphasis on the protection of the human rights and dignity of HIV-infected persons, including people with AIDS. In fact, the World Health Assembly has stated that this policy is critical to the success of national and international AIDS prevention programmes. Therefore the protection of the rights and dignity of HIV-infected persons is an integral part of the Global AIDS Strategy.

5.3. The first objective of the Global AIDS Strategy is to prevent HIV transmission. HIV spreads almost entirely through identifiable behaviour and specific actions (sexual intercourse, self-injecting drug use) which are generally—though not always—subject to individual control. In most instances, HIV transmission involves the behaviour of two persons; a change in behaviour of either the HIV-infected or the uninfected person will be sufficient to prevent HIV transmission. However, it must be remembered that HIV is transmitted mainly through behaviour which is private, secret, hidden from society and illegal in some societies.

5.4. For these reasons, the following are critical elements in the design of programmes to prevent HIV infection:

(*a*) The keystone of HIV prevention is information and education, as HIV transmission can be prevented through informed and responsible behaviour;

(*b*) Each person, HIV infected or uninfected, must bear in mind his responsibility not to put himself or other persons at risk of infection with HIV;

(*c*) In addition to information and education, specific health and social services will be required to support risk-reducing behaviour changes.

5.5. If HIV infection or suspicion of HIV infection leads to stigmatization and discrimination (e.g. loss of employment or housing, forced separation from family), persons already infected and those who are afraid that they may be infected will avoid contact with health and social services.

5.6. This contact is difficult even without discrimination, because the activities that create the highest risk for HIV transmission are intensely personal, private, and therefore usually hidden. Some of this behaviour is also disapproved of, or even illegal in some countries, which increases the likelihood of its being hidden, so the persons concerned may already be experienced in avoiding detection. Fear of being reported or previous experience with breaches of confidentiality may well lead those most in need of information, education, and social services to distance themselves from the support that is available and to be less trusting of those who offer support. In this manner, educational outreach is weakened and the difficult task of preventing HIV infection is further complicated. In addition, as persons belonging to groups in which high-risk activities are concentrated are often important participants in promoting behaviour change among their peers, to sever contact with them is to lose vital allies for the prevention and control of HIV infection and AIDS.

5.7. The same concept applies to the provision of care to those who are infected or ill with HIV. If persons who are infected or ill do not seek the best available information or health or social support, then both the individual and society suffer, because of the resulting inability of the public health services to provide the necessary assistance.

5.8. To present HIV infection effectively, persons whose behaviour increases their risk of exposure to HIV must be informed, educated and provided with health and social support. Persons suspected or known to be HIV-infected should remain integrated in society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others. Exclusion of these persons would be unjustified in public health terms and would undermine the public health programme to prevent HIV infection.

5.9. For these reasons, discrimination endangers public health; stigmatization itself represents a threat to public health. In summary, protecting the human rights and dignity of HIV-infected people, including people with AIDS, and members of population groups, is not a luxury—it is a necessity. It is not a question of the "rights of the many" against the "rights of the few"; the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of the infected persons.

5.10. The solution is to inform and educate not only the individuals with high-risk behaviour about prevention of HIV infection, but also the general public, health workers, people in the workplace and others in a position to create discrimination.

5.11. WHO believes that it will be essential for governmental and non-governmental organizations working in the human rights field to play an active and proactive role in this area. Such organizations, particularly at the national and local levels, must help prevent discrimination against HIV-infected persons, persons with AIDS or stigmatized population groups. An informed and alert human rights network can help through information and education about HIV and AIDS and through promotion of the human rights and dignity of all persons.

5.12. The policy of avoiding and overcoming AIDS-related discrimination also has a firm base in international human rights law and encompasses all human rights and fundamental freedoms and restrictions or limitations thereto. The Universal Declaration of Human Rights defines rights that are now being threatened by discriminatory reactions to AIDS, including the rights to housing, employment, education, access to medical care, and freedom of movement.

5.13. Furthermore, the Declaration states categorically that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind". Conventions and other human rights instruments that have been based on the Universal Declaration echo this principle of non-discrimination while giving legal substance to the specific rights that are their particular focus.

5.14. In the context of HIV/AIDS and human rights, a point needing special attention is the acceptance under international law that individual rights may be limited if to do so is genuinely in the interests of the community. General welfare, public health and rights and freedoms of others are three distinct grounds for restricting human rights, and a range of human rights and fundamental freedoms can be restricted invoking these grounds if respect for the principle of non-discrimination is maintained. In the interpretation and application of human rights law, restrictions on public health grounds are a rare exception. The vital importance of the public health rationale for avoiding AIDS-related discrimination is that it demonstrates not only that it is unnecessary to impose general limitations on human rights, but that it is likely to be counterproductive to do so. It is important that "public health" not be used as a pretext to limit human rights unless based on a true public health rationale. An isolated example of individual rights being justifiably limited would be the extreme situation where one individual deliberately and purposefully set out to infect another. However, this has not been shown, anywhere, to be a sufficiently serious public health problem to warrant a general limitation on fundamental freedoms. International law and public health policy are therefore in agreement on the need for non-discrimination and the protection of human rights and dignity.

6. Human rights

6.1. The preamble to the Constitution of WHO declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". This notion is also contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights, where States parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and undertake steps to achieve the full realization of this right, including the prevention and control of epidemic diseases and the creation of conditions which would assure medical service and medical attention to all in the event of sickness.

6.2. Both the World Health Assembly and the International Conference on Primary Health Care held in Alma-Ata, USSR, in September 1978 have proclaimed the right to health in the context of "Health for All by the Year 2000" and WHO's principal effort towards the achievement of this right has been through its programmes. This can only be done through public health measures based on biomedical progress and an atmosphere of public comprehension. As the WHO Constitution itself declares that the right to health must be without discrimination, the member States of WHO have already accepted this principle in their mutual relationships.

6.3. Human rights in relation to health are covered by a wide spectrum of international instruments in addition to the WHO Constitution and the International Covenant on Economic, Social and Cultural Rights. In addition to the International Bill of Human Rights, which includes the above Covenant, other instruments expressly cover the prevention of discrimination, human rights in the administration of justice, employment policy and social welfare, progress and development, all of which relate to concerns raised by HIV/AIDS. These instruments, in turn, involve other international organizations, particularly the human rights bodies of the United Nations family, as well as non-governmental organizations and other actors. WHO is seeking a broad coalition of all concerned for the purpose of bringing together the strengths of their disciplines to reaffirm the sound basis in international law for the prevention of discrimination and the protection of the rights that are threatened in the context of AIDS.

6.4. The international code of human rights law is laid down in a series of instruments, which, in addition to those already referred to, include: the United Nations Charter and other instruments adopted under the aegis of organizations of the United Nations family; regional instruments, including the American Declaration on the Rights and Duties of Man, the American Convention on Human Rights, the European Convention for the Protection of Human Rights and Fundamental Freedoms, the African Charter on Human and Peoples' Rights and the European Social Charter as well as others covering specific rights in greater detail.

6.5. Apart from these instruments, there are other human rights documents of international purport, covering such matters as human experimentation and biomedical ethics. These issues will not be dealt with in this document, since they do not lend themselves to any solutions by the application of the existing norms and guidelines, and may therefore be better dealt with in other forums.

6.6. The international code of human rights law declares and protects some 40 to 50 different rights, each specifically defined, "for everyone . . . without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". Among these are:

(*a*) The right to life;

(*b*) The right to health;

(*c*) The right to liberty and security of person;

(*d*) Freedom from inhuman or degrading treatment or punishment;

(*e*) The right to freedom of movement;

(*f*) The right to privacy;

(*g*) The right to marry and to found a family;

(*h*) The right to work;

(*i*) The right to education;

(*j*) The right to social security, assistance and welfare.

6.7. The legal enforcement of this code, in the conventional sense of the term, leaves much to be desired, in the absence of a single compulsory jurisdiction with such powers. Nevertheless, methods for the monitoring and supervision of international human rights instruments are being developed by human rights bodies whose decisions are, in practice, followed by the States concerned. More than half of the world's sovereign States are bound by the two international Covenants and accept the jurisdiction of the supervisory organs which they establish. An increasing number of these States allow individual complaints to be directed to the Human Rights Committee established by the International Covenant on Civil and Political Rights.

6.8. These jurisdictions and bodies are developing a "case law" or "constant jurisprudence" concerning the different parts of the code for which they are responsible. This case law will assist in resolving those problems which pertain to AIDS and human rights.

6.9. In the code, certain rights are absolute, such as freedom from torture or inhuman or degrading treatment or punishment, and may not be derogated from under any circumstances, even in time of war or of public emergency. Other rights are couched in the language of limitations and restrictions, in order to define their boundaries. In such cases, the code declares a "core" right and then proceeds to state that there shall be no interference with or restriction or limitation of this right unless provided for or prescribed by law and necessary in a democratic society for the protection of one or more of the specified public interests. Detailed conditions have been elaborated through the examination of States' reports, United Nations studies and the work of special rapporteurs.

6.10. Article 29 of the Universal Declaration of Human Rights contains the fundamental provision concerning restrictions of human rights. Individual articles of the two Covenants effectively apply and develop this general provision and indicate the fields in which exceptions may be permitted, for example, Articles 4, and 8.1 *(a)* of the International Covenant on Economic, Social and Cultural Rights and Articles 4, 12.3, 13, 18.3, 21 and 22.2 of the International Covenant on Civil and Political Rights. The list of exceptions includes such items as national security, public order, safety and morals, the general welfare and the protection of the rights and freedoms of others. Most importantly, "public health" or what we may term here the "public health exception" is included as a measure restricting the exercise of a right or freedom with the intention of removing or reducing a claimed danger to public health.

6.11. Such a provision must not be understood, however, as taking away with one hand what has just been given with the other. The existing case law has been unanimous in holding that any State wishing to justify any interference with, or limitation or restriction of, any declared "core" right has the burden of proving affirmatively that the restriction was: (*a*) prescribed by law, (*b*) necessary, (*c*) in a democratic society, (*d*) for the protection of one or other of the legitimate interests of society.

6.12. In the light of the above, we can consider the problems which the current and prospective spread of HIV/AIDS are likely to present in the context of human rights and what options may exist for their resolution. In doing so, account will need to be taken of the time span covering the post-war development of international human rights law.

6.13. At the time of the adoption of the Universal Declaration, in December 1948, shortly after the entry into force of the WHO Constitution, biomedical science was considerably less evolved than it is today. Isolation and quarantine remained a conventional technique for attempting to contain the international spread of disease, although many had already criticized such measures as largely illusory and ineffective. Indeed, had the HIV/AIDS pandemic occurred at the time, it would have been impossible with the technology of the period to identify the causative agent. Measures to prohibit discrimination against disabled persons were not introduced into the code until 1975 and there are still no express provisions covering the rights of the sick in relation to discrimination, save as regards medical service and medical attention. With this in mind, the provisions of the code as a whole should be viewed in the light of present-day knowledge, that is to say that the public health exception should be taken as applicable only in the light of actual medical justification and not merely as a means of assuaging unreasonable public fears and condemnations.

7. HIV/AIDS AND HUMAN RIGHTS

7.1. In the *Guidelines for the Development of a National AIDS Prevention and Control Programme*, WHO has stated the following:

> Personal and public reaction to AIDS throughout the world has been of considerable depth and extent. Fear of AIDS and stigmatization of different groups (homosexual men, haemophiliacs, female prostitutes) have become common. Wherever those free from HIV feel threatened by those infected with HIV, especially where the latter are perceived to belong to a defined group such as homosexuals and drug addicts, there may be calls for marking out and isolating those infected . . . As the toll of clinical diseases rises, there will be increasing pressure on the authorities to take further action and adopt approaches that may or may not be effective or have any rational justification.

7.2. In fact, what is critical for the control of any such infection is not whether it is endemic, epidemic, or (in the extreme case) pandemic, but how the infective vector travels from one person to another, for how long any given person is liable to remain infectious, and whether at any given time there are any means either for protecting another person from the infection, or for combating the infection once he or she has acquired it.

7.3. HIV/AIDS bears little resemblance to previously known infectious diseases. Unlike the vectors of other diseases, HIV is not transmitted through droplet infection, insect or other parasite infestations, polluted water or ordinary social contact. Moreover, infected persons fall essentially into three groups: the sexual partners of infected individuals, those who receive contaminated injections or transfusions, and the babies of infected women. Where the incubation period—that is, the time between infection and the moment that the infected person begins to present identifiable symptoms—of most of the more common infectious diseases is measured in days or, at most, weeks, that for AIDS may be several years, during all of which time the carrier is potentially infectious.

7.4. The result of measures which do not reflect these considerations would be that those persons needing information, education, counselling or other support services would be "driven underground". The person who fears he may be infected would be reluctant to seek assistance out of fear of being reported—with severe personal consequences. The net result would be to seriously jeopardize educational outreach and thereby exacerbate the difficulty of preventing HIV infection.

Policy options

7.5. WHO has reported that no region of the world is now free from AIDS. With no vaccine or cure yet available, all governments are therefore faced with the task of identifying and adopting measures which offer a realistic prospect of limiting its spread within their populations. From the viewpoint of their impact on human rights, such measures may be most conveniently grouped into three categories:

(*a*) Measures which do not lend themselves easily to an examination within the general human rights context, and are better dealt with individually;

(*b*) Measures which may have adverse effects and therefore can only be implemented with the explicit, free and informed consent of the individual concerned;

(*c*) Measures entailing some degree of direct or indirect compulsion.

7.6. Measures in the first category, which are not dealt with here, include the following:

(*a*) Research into the pathophysiology of the disease, its modes of transmission and the development of vaccine and curative drugs;

(*b*) Ensuring the safety of blood for transfusions, blood products for use in treatment, semen for artificial insemination, and other cells, tissues and organs for transplantation;

(*c*) Preventing the re-use of needles, syringes and other skin-piercing or invasive equipment without proper sterilization;

(*d*) Making safety devices, such as condoms, more widely available, especially to persons who practise high-risk behaviour;

(*e*) Facilitating access to sterile needles and syringes;

(*f*) Health information, education and promotion programmes, directed either at the general public or at groups particularly at risk—such as prostitutes of either sex, their clients, self-injecting drug users, and homosexual and bisexual men.

7.7. Such measures raise legal and ethical issues, a number of which have been dealt with by WHO's Global Programme on AIDS in global and regional consultations and through consensus statements emerging therefrom.

7.8. *Measures requiring explicit consent* include:

(*a*) The voluntary testing of individuals for HIV infection either anonymously (that is, without being required to give a true name, or any other identifying particulars), or with stringent safeguards for confidentiality;

(*b*) Counselling of individuals, both before and (if the result is positive) after they are tested;

(*c*) Voluntary treatment to mitigate the effects of infection, or to achieve modifications of their behaviour which they themselves desire; thus, for example, it should be "the responsibility of any athlete participating in a combative sport with direct body contact who has a wound or other skin lesion to report it immediately to a responsible official, and to report for medical attention, or of persons who know they are HIV-infected to seek medical counselling about further participation in sports".[1] These measures are recommended by public health experts. Provided that they are undertaken completely voluntarily—that is, after a full explanation of all the possible consequences, and with the explicit, free and informed consent of the person concerned, obtained without the application of any illicit pressures, whether in the form of promises or of threats—there can be no objection to them on human rights grounds. Therefore these need not be further considered herein.

Measures entailing compulsion

7.9. Compulsion may take many different forms. The most obvious is the use, or the threat of use, of direct force. But making an act (e.g. refusal or failure to undergo an HIV test) criminal is also a form of compulsion; as are express or implied threats of any kind—such as that the person concerned will be deprived of some benefit if he or she does not submit to the desired procedure. It is this group of measures which carries clear risks of violating human rights.

7.10. If we set aside extreme measures, such as the screening of a whole population for HIV antibodies, declared by WHO to be "unnecessary and unrealistic", we are left with a group of measures which may be feasible in practice and could therefore be realistically considered by public authorities, in order to impose some kinds of restriction on actual or potential HIV-infected persons so as to minimize the likelihood of their passing their infection on to others. These restrictions, which are considered below, could be of several kinds.

7.11. Before any restriction can be imposed, one needs to identify the persons concerned. This can only be done by some kind of screening, either for one or more attributes regarded as indicators of *probable* infection, or by testing directly for *actual* infection. All the remaining measures therefore necessarily entail a direct or indirect assessment of the seropositivity of the persons concerned and the reporting of the result to someone else—as, for example, by establishing registers of such persons, by making HIV infection a notifiable disease, or by compulsorily tracing and informing the sexual partners of HIV-infected persons.

7.12. Since it would never be possible in practice—let alone justifiable on either public health or human rights grounds—to carry out compulsory screening of the entire population of even a small nation, such screening has in practice concentrated on previously specified groups. For example:

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[1] *Consensus Statement from Consultation on AIDS and sports* (WHO, Geneva, 1989).

(*a*) Persons thought to be at special risk of both acquiring the infection and passing it on to others, such as prostitutes of either sex, their clients, self-injecting drug users or homosexual or bisexual men;

(*b*) Persons—whether citizens or aliens—seeking entry at a frontier, port, or airport;

(*c*) Hospital patients;

(*d*) Persons wishing to marry;

(*e*) Prisoners;

(*f*) Persons engaged in various particularly sensitive occupations.

7.13. Restrictions which might be contemplated for those found to be HIV-infected include the following:

(*a*) Quarantine, isolation or detention;

(*b*) Refusal of entry into a country;

(*c*) Denial of marriage, employment, housing, social services, attendance at educational or other establishments, or of some other benefit.

It is necessary to distinguish here between those restrictions which constitute a denial of human rights, such as the right to marry, and those which do not constitute a denial of a human right, such as entry into a country for aliens. In the case of the former, the specific human right denied may be invoked, while with respect to the latter the best and often the only way to seek remedy is to seek the application of the principle of non-discrimination.

Testing the ligitimacy of policies

7.14. The remainder of this document considers the legitimacy of the various permutations and combinations of these measures in different circumstances by reference to the international code of human rights law.

7.15. Where the code allows *any* restrictions of any of the human rights which it seeks to protect, such a restriction will only be considered justifiable under the following conditions:

(*a*) If determined by law;

(*b*) If necessary in a democratic society;

(*c*) If necessary for the protection of a "legitimate aim" which falls within one of the categories specifically listed in the relevant provisions of the applicable instrument.

7.16. The second of these requirements in turn entails that (*a*) there must be a "pressing social need"; and (*b*) the restriction must be "proportional", weighed both against its adverse effects on the persons on whom it is imposed and against the public interest in the free exercise of the right concerned.

7.17. For the first requirement—"determined by law"—the State concerned must enact, by the procedures normally required for that purpose under its constitution, legislation which satisfies the necessary criteria; the law concerned must be sufficiently accessible, clear and precise for the ordinary individual to be able to regulate his or her conduct accordingly. He or she must be able—if necessary with appropriate advice—to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail. It is hereafter assumed that any restrictions on human rights imposed by public authorities for the purpose of limiting the spread of HIV among their populations will satisfy this test.

7.18. The next question will be whether the restriction is designed to serve a "legitimate aim" for the protection of which restrictions on the right under consideration may be allowed in appropriate circumstances. Only two are relevant in the present context: the protection of the rights and freedoms of others and the protection of public health.

7.19. Among the rights and freedoms of others the most important one that needs to be considered here, at least so long as there is no cure for AIDS, is the right to life. Apart from the question of the sanctioning of certain forms of conduct in order to protect this right, in relation to AIDS this right can only impose on a State the obligation to take what measures it reasonably can to prolong the lives of its inhabitants where this can be done at a cost that is reasonable, both in terms of resources and restrictions on other human rights.

7.20. Since AIDS, once the full clinical syndrome has developed, is almost invariably fatal and since there is at present no known cure for it, every new HIV infection is a potential fatality and thereby threatens the right to life of the person infected. Accordingly, every measure which succeeds in reducing the spread of HIV will not only serve "the protection of public health", but will automatically serve to protect the right to life. It follows that it will be enough to consider such measures under the aspect of the protection of public health and that it will be unnecessary to consider them separately from the point of view of the protection of the right to life, and so (with few exceptions) of "the protection of the rights and freedoms of others".

7.21. The final criterion for testing the legitimacy of such measures is proportionality of the balance between the benefits to be expected, their adverse consequences for the persons concerned, and the public interest in the free exercise of the right being restricted. All these need to be considered in light of the degree and the kind of a "pressing social need" presented to the Government of the State concerned.

7.22. This balance will therefore be the principal focus of any consideration of the human rights at issue. For this purpose, any views already expressed by responsible and reputable public health experts, as well as by governments, on the utility of the measures concerned will clearly be important, though not necessarily conclusive. These views may of course change hereafter, in light of the advancing knowledge and experience of the public health aspects of AIDS. The same considerations apply to decisions of the international organs competent to interpret and apply human rights law. So far no case specifically about AIDS has been decided, and there are few in which restrictions upon human rights on public health grounds have been considered. Nevertheless, the examination of States' reports on the implementation of human rights treaties enables the human rights bodies to assess the compatibility of national laws and practices in the area of AIDS with the existing human rights standards.

8. Rights and freedoms

8.1. The following analysis of HIV/AIDS-related measures in relation to human rights and freedoms is grouped under these main headings, which are not necessarily exclusive:

(*a*) The right to privacy;
(*b*) The right to liberty and security;
(*c*) The right to freedom of movement;
(*d*) The right to marry and to found a family;
(*e*) The right to work;
(*f*) The right to education;
(*g*) The right to social security, assistance and welfare;
(*h*) Freedom from inhuman or degrading treatment or punishment;
(*i*) The right to equal protection of the law;
(*j*) Public emergencies.

8.2. These rights and freedoms appear sometimes under virtually identical definitions and at others under different definitions in the international human rights instruments. For certain of them, such as the right to work, or the right to social security, assistance and welfare, the precise meaning of the formulation is controversial, or the circumstances under which the benefit is to be obtained not specified. Nevertheless, they are sufficiently general to serve as indicators for the consideration of measures taken on account of AIDS which might entail adverse consequences for the human rights of individuals.

A. *The right to privacy*

8.3. Under this heading is considered the impact of measures designed to limit the spread of HIV by screening for potential or actual HIV infection.

8.4. Several possible measures would necessarily entail interferences with the individual right to privacy, which the State concerned would need to justify under the established criteria. These measures include:

(*a*) Mandatory testing for HIV infection;

(*b*) Compulsory registration of persons considered likely to be infected with HIV, but who have not been tested;

(*c*) Mandatory collection, storage and processing by public authorities of personal information about those who are suspected of being infected or have been tested;

(*d*) Making AIDS, or HIV infection, a notifiable disease;

(*e*) Disclosure of test results, or of other personal information, to third parties;

(*f*) Criminalization of behaviour thought to be conducive to the spread of AIDS.

Routine screening

8.5. The WHO position on routine screening is the following:

> Routine screening of high-risk groups (homosexuals and heterosexuals with multiple sexual contacts and intravenous drug users), of other groups (military personnel, international travellers and hospital patients) and as a prerequisite for marriage is of little use in controlling or slowing down the AIDS epidemic.[2]

8.6. In any case, a negative HIV test gives no guarantee that the person tested is not a carrier of the virus: he or she might acquire the infection the following day, or might indeed have already become infected, but not yet have seroconverted.

8.7. Public health experts appear so far to have been unanimous in rejecting *mandatory* HIV screening as an efficacious means for reducing the spread of this infection—except in the case of voluntary donors of blood, semen, or other cells, tissues or organs. Some countries do not apply the "informed consent" requirement for blood donors, at least not in the way that "informed consent" is generally understood. In the view of the experts, efforts to *compel* testing would be counter-productive: knowledge that a test would be required would simply deter those who most need to be educated and counselled from seeking medical advice: HIV infection would effectively be driven underground, when the most pressing need is to bring it to the surface.

8.8. Instead, public health experts recommend a less coercive, and in their view more efficacious, alternative, namely increasing the availability of *voluntary* testing, together with a broadly based information and education campaign aimed at encouraging the abandonment of high-risk behaviour. The purpose is to identify infected persons—who might not otherwise

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[2] *AIDS Diagnosis and Control: current situation* (WHO, Geneva, 1987), p. 3.

change their behaviour because they do not know they present a risk—so that they can be intensively counselled not to engage in behaviour that might be dangerous to others.

8.9. It is pertinent to note that the Committee of Ministers of the Council of Europe, explicitly taking into account the European Convention on Human Rights, has recommended that "there should be no compulsory screening (for HIV infection) of the general population nor of particular population groups" and that "health authorities should instead invest resources in the setting up of sites . . . for voluntary testing . . .".[3]

8.10. In the light of all these considerations it seems unlikely, in present circumstances, that any scheme for mandatory screening would satisfy the test of being "necessary in a democratic society" for the protection of public health; the interference with the right to privacy, and the severe adverse consequences which would flow from it to the individuals concerned, and to society at large through the limitation placed on the right to privacy, would appear to outweigh any public health benefits which could reasonably be expected—if indeed any exist.

Compulsory registration of suspected HIV carriers

8.11. Manifestly, the entry of one's name on a register maintained by a public authority of what would effectively be regarded as a list of potential dangers to the community would be a grave violation of a person's privacy. Further, in order for such a measure to be effective, it would need to be enforced by law.

8.12. Such a measure could not pass the stringent tests implied in the phrase "necessary in a democratic society" without overwhelming evidence of its efficacy in public health terms, coming from reputable public health experts. So far as is known, no such evidence exists. The State concerned would also need to show that no measures existed which had less dramatically adverse consequences for the persons concerned, or for society generally, or could be expected to have similarly beneficial results for public health. That burden too would be decidedly difficult to discharge.

Mandatory collection and storage of information

8.13. Schemes which include the mandatory collection, storage, and processing by a public authority of personal information about individuals suspected of or tested for HIV infection (including, for example, test results, and answers to questions about sexual activities, partners, and drug use) would involve a clear interference with the right to privacy—*unless* the information was protected by the strictest rules of medical confidentiality or by complete anonymity at the time of collection, so that it could never be traced back to an identifiable individual.

8.14. In order to justify such an interference, the State concerned would need once again to establish proportionality with a legitimate aim. In the case of mandatory collection and storage of information, however, it is not immediately clear what aim would be served.

8.15. If the collection is made by reference to identifiable individuals, and its purpose is to impose restrictions on some or all of them, then its establishment and maintenance would only be justified if *both*: (*a*) the obtaining of the information, by testing or by the creation of registers of potentially "dangerous" individuals, could be justified in its own right, which is unlikely to be the case; *and* (*b*) the restrictions themselves could be justified independently.

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[3] *Guidelines for the Drawing up of a Public Health Policy to Fight AIDS*, Appendix to Recommendation No. R (87) 25 concerning a Common European Public Health Policy to Fight the Acquired Immunodeficiency Syndrome.

8.16. If, however, the only purpose of such information-gathering would be to ascertain HIV prevalence or to study the epidemiology of HIV infection, this can be achieved far less intrusively by using only anonymous samples. Public health experts are in any case agreed that the assurance of anonymity is more conducive to securing compliance with testing schemes, and thereby make the information more reliable.

AIDS or HIV infection as a "notifiable disease"

8.17. Collecting and storing information is a consequence of making AIDS or HIV infection a "notifiable disease". There are two possible variants:

(*a*) To require notification to a public authority of all cases of AIDS or HIV infection as and when they become known, without any identifying particulars from which the patients could be traced, or else subject to the strictest rules of medical confidentiality; or

(*b*) Require medical practitioners, by law, to report to a public authority all cases of the disease which they encounter among their patients, in what would otherwise be a breach of medical confidentiality—that is, *with* identifying particulars, and *without* adequate guarantees of confidentiality thereafter.

8.18. Here precisely the same considerations apply as in the general case considered in the previous Section. If identifying details *are* to be recorded, this clear interference with the right to privacy would have to be specifically justified, in the face of the accumulating evidence that it would deter some—perhaps many—possible HIV carriers from coming forward to be tested, knowing that their condition, if they were found to be HIV-infected would be *identifiably* reported to a public authority.

8.19. However, if the entire scheme were subject to the strictest compliance with the general rules of medical confidentiality—or, better still, entailed only anonymous notification from the outset—there would be no obvious objections.

Disclosure of information

8.20. A policy permitting or requiring the disclosure of the results of HIV tests to third persons without consent, or which permits the improper discovery by third persons of those results, also amounts to an interference with privacy.

8.21. In order to justify such a policy, the State concerned would need to show that it was necessary for the protection of the rights of others (e.g. the patient's sexual partner(s), or his or her medical attendant, dentist, or other health workers) or, more generally, for the protection of public health. However, the available evidence suggests that such a policy is not effective. Ever since special clinics were established in many countries at the beginning of this century to deal with sexually transmitted diseases, it has been recognized that a guarantee of confidentiality is an indispensable condition for encouraging people to seek treatment, and thus reduce the spread of these diseases.

8.22. This is particularly true in the case of AIDS, where one wants to prevent infected persons from "going underground", out of the mainstream of health care and education. Current health practice is to protect the privacy of the infected individual and to maintain the strictest confidentiality concerning his or her medical records.

8.23. Breach of confidentiality might, however, be warranted in exceptional circumstances—where, for example, despite counselling and advice, the patient continues to have unprotected sexual intercourse with his or her partner, having been warned by the doctor both of the dangers of doing so and of the doctor's intention to make the disclosure if the patient does not; or if the patient is a health worker and is consistently negligent in observing routine hygiene

precautions, or fails to follow medical advice about his or her work. If doctors were allowed to breach confidentiality in such circumstances, this would of course have to be defined with sufficient precision to comply with the requirement that the interference with privacy be "in accordance with the law".

Criminalization of behaviour

8.24. In some jurisdictions, consideration has been given to the imposition of penal sanctions on persons exposing others to HIV, whether intentionally or recklessly. Such action might be taken under the general criminal law, laws relating to sexually transmitted disease, or under specially adopted legislation.

8.25. Such prosecutions would have an impact on privacy rights and their application would pose difficult problems of proof, but might be held to be justifiable on the grounds of the protection of public health, or of the rights and freedoms (and especially the right to life) of others, *provided* that the offence could be defined sufficiently precisely to meet the requirements of legal certainty and foreseeability. It is an elementary proposition not only of international human rights law, but of virtually all domestic legal systems, that the ingredients of any criminal offence must be sufficiently precise for any person contemplating the commission of a particular act not to be in any doubt as to whether or not that act is criminal.

8.26. Accordingly, the definition of any such offence would have to specify clearly how the accused may be held accountable. This would necessitate proving the following:

(*a*) The accused knew that he or she was HIV infected;

(*b*) The accused knew that his or her actual conduct carried a substantial risk of infecting another person;

(*c*) It was this conduct which in fact infected that other person;

(*d*) The other person did not give knowing consent to the risk of being infected.

8.27. WHO believes that such cases will be rare. Few human beings set out intentionally to kill another and it cannot be assumed that HIV-infected persons will act irresponsibly. The important point is that voluntary compliance, voluntary control, voluntary behaviour change and voluntary testing must constitute the policy to control the spread of HIV. This approach has been effective and must be continued.

B. *The right to liberty and security*

8.28. In order to determine whether the protection of the international human rights instruments applies to the deprivation of liberty, account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question.

8.29. Once there has been a lawful deprivation of liberty, mere modifications of the conditions of detention—such as isolation imposed on a prisoner as a disciplinary measure—will not be regarded as constituting independent deprivations of liberty. Such treatment may, however, raise an issue of compliance with the right not to be subjected to inhuman or degrading treatment (see below).

8.30. The following possible public health measures would appear to involve a deprivation of liberty:

(*a*) Compulsory quarantine, e.g. by enforced confinement or isolation in a hospital or a hospice;

(*b*) Compulsory internment in a colony removed from the rest of society.

8.31. Such measures would then have to satisfy the test that they are not arbitrary, but are taken on a ground, and in accordance with a procedure, established (or prescribed) by law.

8.32. In order to justify the measures under consideration, the State concerned would have to establish:

(*a*) In the case of compulsory blood testing, that it was necessary to prevent the spread of HIV infection;

(*b*) In the case of detention, both that the individual concerned had the infection and that his or her detention was necessary for the prevention of its spread.

8.33. The views of public health experts on the effectiveness of compulsory blood testing as a measure to prevent the spread of HIV infection have been set out above and do not need to be repeated here; suffice it to say that they make it extremely doubtful that such a measure could be justified under international human rights law.

8.34. WHO has expressed the firm view that detention of any kind is not warranted for the prevention and control of the spread of AIDS:

> There is no public health rationale to justify isolation [or] quarantine, . . . based solely on the fact that a person is suspected or known to be HIV infected. The modes of HIV transmission are limited (sex, blood, mother-to-child) and HIV spreads almost entirely through identifiable behaviour and specific actions which are subject to individual control. In most instances, the active participation of two people is required for HIV transmission, such as in sexual intercourse and in sharing contaminated needles or syringes. . . . HIV infection is *not* spread through casual contact, routine social contact in schools, the workplace or public places, nor through water or food, eating utensils, coughing or sneezing, insects, toilets or swimming pools.[4]

8.35. Moreover, WHO has adopted, within its recommended strategy for the prevention of the spread of HIV, the following principle:

> . . . persons suspected or known to be HIV infected should remain integrated within society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others. Exclusion of persons suspected or known to be HIV infected would be unjustified in public health terms and would seriously jeopardize educational and other efforts to prevent the spread of HIV.[5]

8.36. There would appear to be no public health justification for a policy of compulsory segregation or isolation of prisoners who are known or suspected to be HIV infected or who have AIDS, either in a separate unit or in single cells. If such restrictions are imposed on the prisoner's already limited liberty, they are not to be considered as independent deprivations of liberty, but ought to be considered under the right to liberty. Moreover, they may be open to challenge on the ground that they amount to inhuman or degrading treatment.

8.37. There may be an exception in the case of a genuine emergency—for example if someone known to be, or suspected on cogent grounds of being, infected with HIV is found bleeding copiously and so presents an acute risk of infecting others, and is unable to take care of himself or herself.

8.38. Another exception might be conceivable in the case of a person so disturbed or embittered by the knowledge of HIV infection that, despite intensive counselling, he or she insists on deliberately infecting others.

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[4] *Social aspects of AIDS Prevention and Control Programmes* (WHO, Geneva, 1987).

[5] *Ibid.*

8.39. In either of these cases, such a person's detention might be justified, in the one case until the immediate emergency is over, and in the other until there is no further risk of conduct likely to infect others. However, it should be noted that in the case of *any* detention, all the relevant international instruments require strict judicial control: the detainee must be entitled to take proceedings before a court in which the lawfulness of this detention can be decided without delay (or "speedily"), and release can be ordered if the detention is not lawful.[6]

C. *The right to freedom of movement*

8.40. Freedom of movement comprises an interrelated cluster of issues: entry into a country; abode and movement within a territory; expulsion from a country and leaving a country. Each of these is regulated differently as between nationals of the State concerned and aliens (i.e. non-nationals).

8.41. The present text deals with the first three in order to assess the extent to which, if at all, a State might legitimately impose controls on entry into its territory of those who are HIV infected, restrict their movement within the country, or permit or require their expulsion from it.

8.42. The right to enter a country is confined to nationals of the State concerned; nowhere in any international human rights treaty has any State accepted an express obligation to allow aliens to enter its territory.

8.43. For nationals, the right to enter is absolute and not subject to any restrictions. It could not, therefore, be legitimate for a State to make the entry into the country of its own returning nationals conditional on their taking an HIV test, let alone on obtaining a negative result.

8.44. By contrast, States enjoy a wide discretion over the entry of aliens. The choice of grounds for exclusion is largely a matter for decision by each State. This does not, however, mean that there are no restrictions on a State's ability to control entry for purposes of work, travel, or immigration. Rules of general international law have made a limited impact on this broad power, in particular by affirming the principle of non-discrimination.

8.45. For States, further restrictions are derived from specific treaty obligations, as for example in health matters under WHO International Health Regulations or, more generally, in respect of other rights guaranteed under other aspects of international human rights law, such as respect for family life.

8.46. It is not the case, therefore, that the entry of *all* aliens into a country could be made contingent upon production of a certificate of freedom from HIV infection, or submission to an HIV test. Such a requirement could only be imposed in such cases where the State could establish that it was necessary for the protection of public health.

8.47. WHO has stated:

> Since HIV infection is already present in every region and in virtually every major city in the world, even total exclusion of all travellers (foreigners and citizens travelling abroad) cannot prevent the introduction and spread of HIV.[7]

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[6] International Covenant on Civil and Political Rights, Art. 9 (4); European Convention on Human Rights, Art. 5 (4); American Convention on Human Rights, Art. 7 (6).

[7] *Statement on screening of international travellers for infection with HIV* (WHO, Geneva, 1987).

Hundreds of millions of persons cross international borders each year, by boat, air, rail, motor vehicle and foot, and any screening programme for international travellers would present immense problems.

8.48. The freedom to choose a residence within the territory of a State and to move about freely within that State is guaranteed to nationals and aliens alike, but may be restricted on the usual grounds, including public health. It complements the protection afforded by the right to liberty of the person.

8.49. Any such restriction would have to be strictly justified as being necessary in a democratic society for the protection of public health. However, public health experts have counselled against the introduction of such measures, and thereby their necessity has been called into question.

8.50. The protection against expulsion from a country afforded by international human rights law is more limited and differs in certain significant respects between the various instruments. As regards the protection afforded to aliens, most provide that an alien lawfully in the territory of a State may be expelled therefrom only in pursuance of a decision reached in accordance with the law.

8.51. Under the provisions of the Covenant on Civil and Political Rights, the alien must be given the opportunity to submit reasons against his or her expulsion and have his or her case competently reviewed, the public health exception not being a reason for the non-application of these safeguards.

D. *The right to marry and to found a family*

8.52. A policy of *mandatory* premarital HIV testing, coupled with a denial of a marriage licence if either person prove to be positive, would be a measure interfering with the substance of the right to marry as protected by the international human rights instruments, as indeed would any prohibition of marriage for persons known to be, or suspected of being, HIV infected. The question would then arise whether such a policy could be justified as being "necessary" to reduce either the sexual or the perinatal transmission of the HIV virus. Although these might well be regarded as legitimate aims, it seems exceedingly doubtful that preventing HIV-infected persons from marrying would be an effective means for achieving them.

8.53. For many people today not being married does not bar sexual activity. Even where there are ample opportunities for marriage, a substantial proportion of sexual activity takes place outside it. With marriage barred for some, that proportion could only increase, and probably involve more sexual partners.

8.54. There is no reason to suppose that prohibiting marriage would be an effective means of preventing the transmission of the HIV virus to children. An increasing number today are born outside marriage. Indeed, measures have already had to be taken, at national and international levels, to ensure that they are not discriminated against by comparison with children born to married parents. There is evidence that the great majority of children infected with AIDS are born to unmarried parents.

8.55. WHO has stated the following: "Routine screening . . . as a prerequisite for marriage is of little use in controlling or slowing down the AIDS epidemic".[8]

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[8] *AIDS diagnosis and control; current situation* (WHO, Geneva, 1987), p. 3.

8.56. One of the most serious questions which arises in the context of AIDS is whether it could ever be justifiable for a government to adopt a policy which imposed restrictions on procreation for those identified as HIV-infected.

8.57. The wording of the international provision concerning the right to found a family makes it clear that it must be read subject to the same qualifications as those outlined above for the right to marry—namely that national laws may regulate the exercise of this right, but may not impair its substance. Clearly, therefore, public authorities would not be entitled to interfere with the founding of a family by, for instance, adopting a policy of ordering mandatory abortions or sterilizations—unless this was "necessary" in order to achieve a legitimate aim, and strictly proportional to it.

8.58. Such a policy would presumably have the two-fold aim of seeking to protect the health of both the mother and the unborn child. While these might be legitimate aims, it seems clear for the following reasons that such a policy would be quite unjustifiable.

8.59. As regards the health of the prospective mother, it appears to be the case that the immune system weakens during pregnancy, and physicians are therefore concerned that pregnancy may increase the risk that women who are already infected with HIV will develop full clinical AIDS. However, the need to protect the person concerned from herself could not be considered to be of sufficient weight to justify a measure of this nature, particularly in the case of an individual of full age and in possession of her mental faculties.

8.60. As for the unborn child, perinatal transmission of HIV has been found to occur during pregnancy, delivery, and perhaps also soon after birth. The extent of the risk of transmission by these means is not yet known with any certainty. However, even if it proved to be high, this could not justify such gross violations of human rights as *compulsory* abortions or sterilizations, contrary to the woman's express wishes, any more than one could ever attempt such a justification in cases of genetically transmitted diseases.

E. *The right to work*

8.61. The relevant international instruments provide that everyone has the right to an opportunity to gain his of her living by work which he or she freely chooses or accepts. States have an obligation to take appropriate steps to safeguard this right and/or to protect it effectively.

8.62. The United Nations Committee on Economic, Social and Cultural Rights, interpreted the relevant provisions of the Covenant to include an effective guarantee against arbitrary dismissal as an integral element of the right to work.[9]

8.63. To the extent that some forms of discrimination in this field are permissible, the question becomes whether the ground for the discrimination is objectively relevant to the efficient and proper performance of the duties of the employment.

8.64. It follows that if an applicant for a job were refused employment or an employee were dismissed solely on the ground that he or she was—or was suspected of being—HIV infected, this would constitute an interference with his or her right to work, unless it could be established that the absence of infection was a *bona fide* and *necessary* occupational qualification or that the infection would clearly and substantially affect job performance.

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[9] See, for example, the Committee's consideration of the Report submitted by the Netherlands: "Without a fundamental guarantee against arbitrary dismissal, the right to work would be meaningless" (summary records of the Committee on Economic, Social and Cultural Rights, E/C.12/1987/SR.5, p. 3).

8.65. For example, there might be no interference with the right to work if someone who was HIV infected were not employed in a position requiring travel to countries which bar those who are infected. Nor might there be such an interference if persons were not employed because they were already displaying some symptoms of fully developed AIDS and their prognosis was such that they would either not be in the position long enough or would not be in sufficiently good health to be able to carry out the normal duties of the employment. However, in any case of this kind the situation would be no different if such persons were suffering from any other disease affecting their performance at work. As WHO and the International Labour Organisation (ILO) have pointed out:

> Pre-employment HIV/AIDS screening as part of the assessment of fitness to work is unnecessary and should not be required. . . . There should be no obligation of the employee to inform the employer regarding his or her HIV/AIDS status.[10]

8.66. As for over, HIV-related symptoms manifesting *after* someone has been employed, WHO and ILO state:

> If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made. . . . HIV infection is not a cause for termination of employment. As with many other illnesses, persons with HIV-related illnesses should be able to work as long as medically fit for available, appropriate work.[11]

8.67. Next, the question arises whether the risk of HIV infection leading to neuropsychiatric disorders might be a sufficient reason to avoid employing infected persons in some exceptionally sensitive occupations, such as train drivers or commercial pilots, on the grounds that their faculties might become impaired and thereby put other people's lives at risk. WHO concluded the following:

> . . . governments, employers and the public can be assured that based on the weight of available scientific evidence, otherwise healthy HIV-infected individuals are no more likely to be functionally impaired than uninfected persons. Thus, HIV screening would not be a useful strategy to identify functional impairment in otherwise healthy persons. Furthermore, there is no evidence that HIV screening of healthy persons would be useful in predicting the onset of functional impairment in persons who remain otherwise healthy.[12]

8.68. There do not appear to be any tenable grounds for restricting the involvement of those who are HIV infected in the preparation or distribution of food. WHO has stated: "HIV infection is not spread through water or food, [or] eating utensils".[13]

8.69. The question then arises as to what extent measures may be taken which would interfere with the right to work of a person with HIV/AIDS where his or her ability to perform the work in question is *not* at issue. Here the analysis is a familiar one: any restriction or limitation on the right to work must be prescribed by law and be necessary in a democratic society for one of the specified purposes.

8.70. In the context of AIDS, there is—in the context of the protection of the rights and freedoms of others—a particular purpose for which restrictions might be imposed on the right to work, namely the right of all workers to safe and healthy working conditions. Could this be invoked to justify refusing to employ, or dismissing, someone who is HIV infected (or who refuses to reveal whether he or she is HIV infected) on the grounds that his or her presence constitutes a danger to fellow workers?

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[10] *Statement from the Consultation on AIDS and the Workplace* (WHO, in association with ILO, Geneva, 1988).

[11] *Ibid.*

[12] *Statement on Neuropsychological Aspects of HIV infection* (WHO, Geneva, 1988).

[13] *Social Aspects of AIDS Prevention and Control Programmes* (WHO, Geneva, 1987).

8.71. In the views of public health experts, such a measure would not meet the test of necessity. WHO and other public health experts have emphasized that there is no risk of infection where there is no direct contact with the blood, semen, or vaginal secretions of infected individuals. Because few jobs outside the provision of health services involve contact with these body fluids, other employees are therefore safe from infection whilst at work. WHO has stated:

> HIV infection is not spread through casual contact (or) routine social contact in . . . the workplace.[14]

> In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker.[15]

8.72. The risk of employees coming into contact with such infected body fluids is likely to arise only from accidents and their treatment. According again to the public health experts, in a situation requiring first aid the standard precautions taken to reduce the risk of transmitting other blood-borne infections, including hepatitis B, will be equally effective against HIV.

8.73. Finally, the question whether health workers should be treated as a special case needs to be addressed. Consideration has already been given to the special risks to which they may be exposed in *acquiring* HIV infection: we must now consider the risks of their *transmitting* it.

8.74. Clearly, those who are routinely involved in invasive procedures—for example, medical and dental surgeons, nurses inserting cannulae or even just giving injections or taking blood samples—present a special risk of transmitting HIV to their patients if they themselves carry it, *and* if they do not observe the routine precautions designed to prevent *any* blood-borne infections from which they suffer from being transmitted.

8.75. However, health workers are themselves uniquely aware of this risk and how it is best avoided—e.g. by withdrawing from particular aspects of their work which embody such a risk—and are generally highly responsible people. Indeed, there is not a single reported case of a health worker infecting a patient with HIV. Accordingly, the circumstances in which it would be justified to interfere with the right to work of an HIV-infected health worker would have to be quite exceptional, e.g. if he or she were consistently negligent in observing the routine precautions or failed to follow medical advice about his or her work.

F. *The right to education*

8.76. Access to education, flowing from the right thereto, implies that measures governing conditions of such access be both for a legitimate purpose and proportionate to the achievement of that purpose. A health policy prohibiting children infected with HIV from attending school would clearly constitute an interference with their right to education.

8.77. The reasonableness of exclusion of children infected with HIV from school is highly questionable. Public health experts have been unanimous in stating that, based on all present evidence, there is no risk of transmitting HIV in school. WHO states: "HIV infection is *not* spread through . . . routine contact in schools" (emphasis in the original).[16]

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[14] *Social Aspects of AIDS Prevention and Control Programmes* (WHO, Geneva, 1987).

[15] *Statement from the Consultation on AIDS and the Workplace* (WHO, in association with ILO, Geneva, 1988).

[16] *Social Aspects of AIDS Prevention and Control Programme* (WHO, Geneva, 1987).

8.78. They state further that (as in the case of accidents occurring at the workplace) accidents at school—where, for example, an infected child is cut, sick, or incontinent—can be dealt with safely by following standard hygienic procedures.

8.79. Accordingly, it is recommended that HIV infection should not be a factor taken into account by education authorities with respect to school admissions, transfers, attendance, or their powers of exclusion from school.

8.80. There may, conceivably, be some exceptional cases, as for example children who are so developmentally delayed or neurologically handicapped as to lack control of their body secretions. In such cases, it might be legitimate to take this fact into account, together with known information about the HIV serological status, when assessing the child's educational needs.

G. *The right to social security, assistance and welfare*

8.81. As regards social security, ratification of ILO Convention No. 102 Concerning Minimum Standards of Social Security of 28 June 1952 entails, *inter alia*, that a State must have a system which provides benefits in respect of at least three of the following:

(*a*) Medical care;
(*b*) Sickness;
(*c*) Unemployment;
(*d*) Old age;
(*e*) Employment injury;
(*f*) Family;
(*g*) Maternity;
(*h*) Invalidity;
(*i*) Survivorship.

At least one of these must be unemployment, old age, employment injury, invalidity or survivorship.

8.82. It follows that a system may be a genuine system of social security even if some risks (e.g. sickness and maternity benefits) are not covered.

8.83. The question then arises whether a government could legitimately stipulate that, if employees were dismissed because they had AIDS or took sick leave because of sickness attributable to AIDS, they could be denied unemployment or sickness benefits to which they would otherwise be entitled. It seems clear that it could not. The guarantee applies to *all* workers. Accordingly, if a social security system provides for the payment of benefits in case of unemployment or sickness, it could not exclude persons with AIDS from that protection.

8.84. To so do would constitute an interference with the individual's enjoyment of this right, which would have to be justified as being necessary in a democratic society for the protection of the rights and freedoms of others or for the protection of public health. It is not evident how this exacting test could be met, as there is no apparent link between curtailing the rights of persons with AIDS to social security, enhancing the protection of the rights and freedoms of others, and protecting public health.

8.85. The second component of the right to social security is social and medical assistance. This right is accorded to *all* those persons—without distinction—who do not have adequate resources of their own. It would therefore not be permissible either to deny social or medical assistance to an individual who meets the relevant economic criteria for it, or to limit the amount of that assistance, solely on the ground that he or she has AIDS. Again, such measures would constitute an interference with the individual's enjoyment of this right.

8.86. The third element is social welfare services. In this connection, the question arises whether it would be permissible for social workers to withhold their services from a person with AIDS and his or her family on the ground that, in providing those services, they run the risk of becoming infected. In seeking the answer, one must bear in mind that one of the tasks of social workers in the face of the challenge posed by AIDS must be to assist those affected by the disease and their families to cope with it, to adjust to their new situation, and to make the necessary modifications to their lifestyles. Failure to provide that assistance would therefore constitute an interference with the rights of the individual and his or her family to benefit from social welfare services.

8.87. As to whether such a withholding of services could be justified on the ground of being necessary to protect the health of the social workers, this has been dealt with above in connection with the right to work. The answer is that it could not; social work entails no contact with blood, semen, or vaginal secretions, and public health experts have made it clear:

> In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker.[17]

H. *Freedom from inhuman or degrading treatment or punishment*

8.88. A State's obligation here is absolute and there are no qualifying clauses of any kind. As a result, *any* failure by a State to comply with its obligations in respect of *any* one of these modes of conduct amounts to a violation of this prohibition; no question of justification can ever arise.

8.89. The question has been raised as to whether the compulsory segregation or isolation of prisoners with AIDS or HIV infection might amount to a breach of this prohibition. Clearly, such a measure would not constitute "torture" although it might amount to inhuman or degrading treatment.

8.90. While the compulsory segregation or isolation of prisoners with AIDS or HIV infection would probably not constitute "inhuman" treatment, it might well, depending on the circumstances, amount to "degrading" treatment, especially bearing in mind that public health experts have said they see no need for it. Principles of medical ethics relevant to the role of health personnel, particularly physicians, strengthen the protection of prisoners and detainees against torture and other cruel, inhuman and degrading treatment or punishment.[18]

I. *The right to equal protection of the law*

8.91. This right derives from the principle of equal protection of the law without discrimination and the prohibition of discrimination in law or in practice in any field regulated and protected by public authorities. It is thus concerned with the obligations imposed on States in regard to their legislation and the application thereof.

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[17] *Statement from the Consultation on AIDS and the Workplace* (WHO, Geneva, 1988).

[18] *Statement from the Consultation on Prevention and Control of AIDS in Prisons* (WHO, Geneva, 1987), para. c.4, and General Assembly resolution 37/194.

8.92. There could be circumstances in which a law which discriminated against people with AIDS or HIV, or which gave them less protection than it gives to others, could constitute a violation of this right *even if no other human right of the persons concerned were being denied or abridged as a result.*

8.93. The areas to which this principle could be applied will vary from one country to another and will depend on the matters which are regulated by law, such as access to public housing or the granting of licences for various activities.

8.94. It follows that an individual with AIDS or HIV may only be subjected to differential treatment in any field regulated and protected by law if it can be established that the distinction has a legitimate aim (i.e. an objective and reasonable justification) and that the means employed are proportionate to that aim.

8.95. The only imaginable legitimate aim would be the protection of public health. However, public health experts throughout the world are on record as saying that this aim is best pursued by *not* discriminating against those who are infected with HIV, or people with AIDS. To take just two examples:

> Discrimination against, and stigmatization of, HIV-infected people and people with AIDS and population groups undermine public health and must be avoided.[19]

> The avoidance of discrimination against persons known or suspected to be HIV infected is important for AIDS prevention and control: failure to prevent such discrimination may endanger public health.[20]

8.96. It is difficult to see how discrimination against persons with AIDS or HIV-infected persons in respect of *any* of their legal rights, or their protection by the law, in any field regulated by public authorities could be justified as a measure proportionate to the legitimate aim of seeking to limit the spread of this infection.

J. *Public emergencies*

8.97. A State may not simply declare a public emergency in order to seek to justify measures that would otherwise be a breach of its international obligations. Whether such an emergency exists is, ultimately, a matter for objective assessment by the international supervisory organs in the human rights field, as is the question whether the measures taken by the State did or did not exceed those "strictly required by the exigencies of the situation".

8.98. The question then arises whether the prevalence of AIDS within a country could ever be so high as to amount to "a public emergency threatening the life of the nation", and so entitle the government of that country to introduce drastic measures to suspend the human rights of its inhabitants. It is difficult to imagine such a situation in the case of a disease which does not have the dramatic virulence of, say, a mediaeval outburst of bubonic plague: the effects of the disease would have to involve the entire nation and threaten the continuance of its whole organized life.

8.99. However, even if one could imagine a scenario where AIDS threatened the survival of an entire nation, one can only speculate what considerations would need to be weighed in the balance. Much would of course depend on whether, by then, any efficient vaccine or cure had been found. If it had, there would certainly be powerful arguments for administering it, if necessary by compulsion—perhaps even if this entailed some incidental risk to the health of a few.

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[19] World Summit of Ministers of Health. London Declaration on AIDS Prevention. 28 January 1988.

[20] *Social aspects of AIDS Prevention and Control Programmes* (WHO, Geneva, 1987).

However, in the absence of a vaccine or cure, it is difficult to see how even the most drastic measures could help to prevent the further spread of a disease and thereby justify derogations on the ground of a public emergency.

9. Conclusions

9.1. The following is a summary of the conclusions that may be drawn from the preceding sections.

9.2. Those public health measures designed to counter the spread of HIV infection which do not entail adverse consequences for any individuals are unobjectionable on human rights grounds.

9.3. The following measures may have adverse consequences but would be acceptable on human rights grounds provided that they are undertaken completely voluntarily—that is, only after a full explanation of all the possible consequences, and with the explicit, free and informed consent of the persons concerned, obtained without the application of any illicit pressures, whether in the form of promises or of threats. These are:

(*a*) Voluntary testing of individuals for HIV infection, either on an "anonymous" basis (that is, without the requirement that the person give their true name), or with stringent safeguards to ensure confidentiality;

(*b*) Counselling of individuals, both before and (if the result is positive) after they are tested;

(*c*) Voluntary treatment to mitigate the effects of infection or to achieve modifications of behaviour.

9.4. The following measures would, in present circumstances, constitute interference with the right to privacy of the individuals concerned, and would not be justifiable under international human rights law on public health (or any other) grounds. These are:

(*a*) *Mandatory* testing of any individuals (other than voluntary donors of blood, semen, or other tissue or organs) for HIV infection, no matter how they are selected;

(*b*) Compulsory registration of suspected HIV carriers;

(*c*) Mandatory collection, storage and processing by a public authority of *identifiable* personal information about persons with AIDS or HIV-infected persons, by making either or both of these a "notifiable disease" by law—*without* protecting the information concerned by the strictest rules of medical confidentiality or, better still, by anonymity;

(*d*) Disclosure of the results of HIV tests to third persons (including health professionals) without consent, or permitting the improper discovery of such results by third persons.

9.5. The following measures, while entailing some interference with the right privacy, might be justified on public health grounds:

(*a*) In exceptional circumstances, informing someone at risk of a patient's known HIV-infected status, even in breach of medical confidence—e.g. where the patient refuses, despite counselling and advice, to take the necessary precautions to avoid passing on the infection to a known sexual partner, or if the patient is a health worker and is consistently negligent in observing routine hygiene precautions, or fails to follow medical advice about his or her work—provided the circumstances in which this was allowed are clearly defined by law;

(*b*) Making it a criminal offence for an HIV-infected person knowingly or recklessly to infect others, provided that the offence could be defined sufficiently precisely to meet the requirements of legal certainty and foreseeability.

9.6. The following measures would not constitute interference with the right to privacy of the individuals concerned:

(*a*) Estimating the prevalence of HIV infection in existing populations by testing fractions of samples taken from individuals, with their consent, for other purposes, and which have been so completely anonymised as to make it impossible to relate them back to the individuals from whom they were taken;

(*b*) Making AIDS or HIV infection a "notifiable disease" by law, *provided* that the information reported is either wholly anonymous in the first place, or is protected by the strictest compliance with the general rules of medical confidentiality—that is, that it could only be released either anonymously or with the explicit and informed consent of the person to whom it relates.

9.7. The following measures would entail violations of the right to liberty and security, and could not be justified on public health (or any other) grounds:

(*a*) Compulsory blood tests;

(*b*) Compulsory isolation or quarantine, e.g. by enforced admission to a hospital or a hospice;

(*c*) Compulsory internment in a colony removed from the rest of society.

9.8. The following measures, although they entail violation of the right to liberty and security, might be justifiable on public health grounds, provided that the person detained has the right to have the lawfulness of his or her detention tested initially, and thereafter periodically, by an independent judicial tribunal:

(*a*) Detention in an emergency of an individual known, or suspected on cogent grounds, to be HIV infected while he or she presents an acute risk of infection to others and is unable to take care of himself or herself;

(*b*) Detention of an individual while he or she is deliberately trying to infect others with HIV.

9.9. As for the right to freedom of movement, it would not be legitimate for a State:

(*a*) To make entry into the country of its own returning nationals conditional on their taking an HIV test, let alone on their obtaining a negative result;

(*b*) To restrict, on AIDS/HIV grounds, the entry of aliens whom it is bound to admit by some specific treaty;

(*c*) To restrict, on such grounds, the entry of aliens where this would interfere with their enjoyment of other rights guaranteed to them under international human rights law, such as the right to family life;

(*d*) To restrict on such grounds, either for nationals or for aliens lawfully within its territory, liberty of movement within that territory or the freedom to choose a residence.

9.10. The expulsion of an individual on the grounds of AIDS or HIV infection would be a violation of the right to freedom of movement if done outside the provisions of the relevant international instruments. Most importantly, the principle of non-discrimination ought to be applied.

9.11. The human right to equality before the law, and to the equal protection of the law, would render it illegitimate to discriminate against individuals on the grounds of AIDS or HIV infection not only in respect of their specifically protected rights, but also in any other fields legally regulated by public authorities.

9.12. To justify the *suspension*—and not merely the various restrictions and limitations discussed in this paper—of any of the human rights and fundamental freedoms guaranteed by international law, there would have to be a "public emergency threatening the life of the nation" on such a scale as to involve the entire nation, and to threaten the continuance of its whole organized life. Even in such a situation, it is difficult to imagine what suspensions of human rights could be justified in the absence of a vaccine or cure.

9.13. Prohibition of marriage for persons known to be HIV infected would be an interference with the substance of the human right to marry, and could not be justified on any grounds.

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